DOCUMENT RESUME

ED 075 400 SP 006 366

AUTHOR	Clarke, Kenneth S., Ed.
TITLE	Drugs and the Coach.
INSTITUTION	American Association for Health, Physical Education, and Recreation, Washington, D.C.
PUB DATE	72
NOTE	63p.
AVAILABLE FROM	American Association for Health, Physical Education, and Recreation, NEA, 1201 16th St., N.W., Washington, D.C. 20036 ($2.50)
EDRS PRICE	MF-$0.65 HC Not Available from EDRS.
DESCRIPTORS	*Athletic Coaches; Athletic Programs; *Counseling; *Drug Abuse; *Drug Education; Drug Legislation; *Health Education; Physical Education

ABSTRACT

This volume is based on the premise that professional preparation for coaching should include viable experiences in drug education, with particular reference to coping with drug-related problems. The first section provides general information on the purposes and effects of drugs, controls, and concepts of doping. The second section deals with four main purposes of drugs in the field of athletics: to cure, control, comfort, and improve. The governmental control of drug abuse is also discussed. The third section presents information on specific drugs, frequency of their use, and the effects. This section also includes charts with new federal and state drug laws. The final section includes some of the problems an athletic coach would encounter when acting as a counselor to his students. An agenda for a symposium "Drugs and the Coach" and a list of sources on drug abuse information are appended. (BRB)

ED 075400

DRUGS AND THE COACH

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Preface

This booklet arose out of a symposium, *Drugs and the Coach*, conducted by the Health Science Department of Mankato State College, Mankato, Minnesota, November 1971 to bring attention to the significant role of the coach as a drug educator/counselor. It was cosponsored by the Minnesota State High School League and the Minnesota State Department of Education, in cooperation with the Minnesota AHPER, Minnesota Association of School Administrators, the Minnesota Association of Secondary School Principals, Minnesota State High School Athletic Directors Association, Minnesota State High School Coaches Association, and ECLIPSE, Inc. (a nonprofit drug crisis prevention center in Mankato).

Via classroom or symposium, professional preparation for coaching should include viable experiences in drug education, with particular reference to coping with drug-related problems. A concerned coach is aware that the country is being inundated with drug and narcotics literature and films. From his viewpoint, however, this abundant material does not correlate the issues of drug use in sports, the street use of drugs by athletes, the apparent legal barriers to a close association with athletes in trouble, and the opportunity of the coach to relate meaningfully to youth within these issues.

The coach has a unique role and a timely potential in this regard that warrants help. He deals with youth at a practical level where interests relate to activity. Yet he is not comfortable with the drug scene; it is not part of his personal experience. He must come to appreciate that attitudes, concepts, and a perspective for effective interpersonal relationships are more powerful tools to possess than mere information about the pharmacology of certain drugs.

The American Association for Health, Physical Education, and Recreation saw value in this approach to drug problems facing its members. It also recognized the composite expertise represented by the faculty assembled for the Mankato symposium. It consequently

authorized its Division of Men's Athletics, Division for Girls and Women's Sports, and School Health Division to assist the symposium director in editing the proceedings for booklet publication.

This is that booklet. It does not pretend to be comprehensive as to drug information but does attempt to give perspective to information. It does not stipulate that drug abuse among athletes is either a neglected or exaggerated concern. It attempts to give better insights into the prevention of drug abuse than "drugs are here to stay" or "that's not my problem." It is not necessary to prove that drugs are a major problem in any or every community. It suffices to say that drug abuse is a current health and social problem, will remain so in changing forms, and needs development of valid cues for awareness and response. Each school has its fads; while the students know what is going on, they need help in interpreting the scene.

No booklet stands alone. As a professional preparation text or reference, the booklet should launch, not conclude, class discussion. Further, a key objective of the Mankato symposium was to serve as a model for others. (See Appendix.) Symposia allow for discussion, conversation, and synthesis. The expertise of the symposium faculty is drawn out only if the participants' remarks can be expanded in panel discussion.

In this regard, this book, as was the symposium, is as relevant to the girls as to the boys. While the text refers essentially to "he" and "him," this is for editorial convenience only. Another editorial convenience concerns references. Since this publication is a liberal editing of a symposium proceedings, it would have been a highly time-consuming task to run down all sources of the speakers' information. Consequently, few footnotes appear. A reference list is found in the Appendix for materials that will complement those found through the usual library indices.

The editor is indebted to the faculty (contributors) whose collective experiences gave credibility to the objectives of the symposium, to the editorial committee members for their invaluable help in condensing the symposium proceedings to a meaningful yet concise booklet, to the AAHPER board of directors for approval of the project, and to the people of Minnesota who gave support to the symposium when it was but an idea.

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Drug Use and Abuse

In 1960, a cyclist died at the Rome Olympic Games after collapsing during a 67-mile road race on a hot day; he had taken a drug to aid his performance. In 1967, two well-known cyclists, one French, one British, also died in a race; they too had resorted to amphetamines in the attempt to achieve competitive superiority.

In the first two months of 1971 in Minneapolis alone, five young persons died from use of drugs: one from a combination of alcohol and amphetamines, one from sniffing a spot remover, two from overdoses of heroin, and one from an overdose of barbiturate.

Youth of today are no more influenced by these headline statements than the coach is with the occasional story of someone else's football fatality. But a typical coach has become concerned and probably has said, "I used to think that the athletic drug problem, whatever it may be, is not *my* problem, and that the street drug problem is not *anyone's* problem in sports. Now I am concerned on both parts." And, if he is typical, one of the most difficult problems he faces is to put that concern to work – meaningfully.

There are two approaches: by opportunity and by obligation. By opportunity is meant pulling a boy aside and having a man-to-man talk on the meaning of life. By obligation is meant the unsolicited encounter, the knock on the door with the boy saying, "Coach, can I talk to you for a minute?"

So, how does a coach talk to an athlete about drugs – meaningfully? (Let us ignore for the moment that many athletes do not come to coaches concerning drugs because of fear of ineligibility or because they do not feel they have a problem.) The drug scene is not

"Doping in sports is the use of a prescription drug for other than clinically justified purposes."

part of the developmental experiences of most coaches. In the coaches' youth, all agreed that the use of drugs in sports was unethical and confined essentially to the then easily understood concept of doping (the use and influence of drugs in the quest of athletic advantage). The use of drugs in the street was considered pathetic but of remote concern, it being confined essentially to the dregs of the ghetto where the rules of society did not reach.

The world, however, changes, and so do some of our rules and seemingly some of our ethics. And the coach is becoming concerned. He used to sense the educational impact of a sports experience justifying the presence of sports in our society: the dedication to discipline, the sacrifice of lesser needs in the pursuit of excellence, the learning about life through teachable moments, the recovery from defeat, and the exhilaration of earned success.

However, the world of sports has provided an environment that, if the concerned coach does not remain *on the offensive* as a professional person, gives tacit approval to athletes who try shortcuts and dabble with virtually anything that is said to improve their performance or return to performance, including drugs. This tacit approval comes about (1) because there is increasing demand on these athletes at all ages for ever-increasing maximal performance and durability; (2) because the evaluation of the coach is increasingly on the scoreboard; and (3) because any unusual "reason" for success is headlined uncritically.

The coach always has been faced with superstitions, traditions, pressures, and misconceptions. Some of these ideas may have confused or run afoul of his concept of sound health care of the athlete. Some are considered part of the colorful gimmickry that adds to the fun of competition and hurts no one. However, the coach is faced now with the need for decisions and actions concerning a problem of a scope, immediacy, significance, and publicity neither previously experienced nor anticipated in professional preparation. Athletes not only are dabbling in sports drugs; some are using street drugs as well.

The concerned coach no longer is willing to remain a passive bystander. He suspects that the discussion of use, misuse, and abuse of drugs in sports, like other ethical matters, has far better sources and criteria for consideration than testimonials and colorful rhetoric.

For example:

- What constitutes doping when an asthmatic athlete may require a stimulant in order to participate?

• Do drugs like anabolic steroids constitute doping if a physician is willing to give them to an athlete?

• If an athlete is caught in possession of a street drug, does kicking him off the squad cause better behavior or does it send him deeper into the drug scene?

• What does the coach do if a drug user in real distress (e.g., bad trips, overdose) is dumped on his step?

Whatever his role, the coach wants to be his own man. He is no more desirous of accepting all that is given him than the modern athlete is. What he must have to cope with in his world must be part of him. He is accustomed to facing his particular problems, to making his own decisions, and to learning from them. He accepts the fact that nothing is automatic in sports and medicine unless it be that experts will differ in their opinions on matters of importance to concerned coaches.

It is through an appropriate drug abuse perspective that the concerned coach comes to see his role in chemical abuse education, coaching as an education profession, and sports as a medium for education. In order to gain a good drug abuse perspective, the coach must know about purposes, effects, and control of drugs and must have a clear concept of doping.

PURPOSES OF DRUGS. The first and primary essential of a drug perspective concerns purpose. If a drug can be considered a chemical with a purpose, it is important to examine first the purpose for which a drug is taken. To use a drug honorably, there must be justifiable purpose. The honorable justification of a drug is the particular anticipated benefit it can offer to a particular clinical condition. Without clinical justification, it remains a chemical, thus the concept of "chemical abuse education."

Drugs can be categorized as to their clinical purposes: to cure, to control, or to comfort. The use of penicillin after a diagnosis of a strep infection is an illustration of the first purpose. The use of insulin to keep a diabetic athlete healthy is an illustration of the second. The use of anesthetics and liniments illustrates the third purpose.

A fourth and more nebulous purpose is to improve. The use of vitamins and tonics is an illustration. The use of LSD and marijuana is another illustration, and use of amphetamines and anabolic steroids another. To put this in perspective, a medical diagnosis of

a clinical deficiency must precede treatment if the purpose of improvement is to have clinical justification.

To examine purpose, therefore, one must consider the need for an accurate analysis of the nature of the benefit being sought and an appropriate selection of the particular drug that is to provide the needed benefit.

EFFECTS OF DRUGS. To be effective, a drug must alter markedly the body's processes. The nature and degree of this alteration is highly variable—from occasion to occasion as well as from person to person and drug to drug. One expert has calculated that 32 factors can alter behavior of a particular drug in a particular person. Dosage, purity, timing, solubility, and tolerance are examples of such factors. The mood of the person also plays a highly significant role in the interpretation of the effects of certain drugs.

Further, the manner in which a drug is administered is a significant factor in influencing a particular effect: the faster a drug gets into the bloodstream, the more powerful its effect. Thus "mainlining" (intravenous injection) is the big daddy of drug administering. Other methods in roughly descending order are intramuscular injection, subcutaneous injection (skin-popping), sniffing (snorting), smoking, and swallowing (dropping). Research on effects must account for all these variables if their findings are to be interpretable.

Anything potent enough to alter the body's metabolism for a benefit is sufficiently potent to harm as well. Consequently, balanced against the desired effect (the purpose) must be side effects and complications. A *side effect* is an effect of a drug other than for the purpose intended. A side effect may not be detrimental at all, such as change in pupil size or increased heart rate. A side effect that *is* a problem (e.g., penicillin reaction, amphetamine insomnia) is called an *adverse effect.* A *complication* is a secondary problem directly related to drug use (e.g., infection from using an unsterilized needle, ineligibility after evidence of possession of an illegal drug).

Other types of effects are categorized as cumulative, potentiating, and antagonistic. A *cumulative* effect occurs when the body has not rid itself of a drug completely (detoxification) before another dose is administered. The murder mystery in which the villainess puts repeated small doses of arsenic in her husband's meal until he quietly passes away is an illustration of a cumulative effect. Marijuana has been found to have this characteristic. A *potentiating* effect (or *synergistic* or *additive*) pertains to the administering of two drugs in which the combined effect is more potent than either would

be alone at that dosage (i.e., 2 + 2 = 5). The deadly combination of alcohol and barbiturates is a common example. The *antagonistic effect* is familiar to us in the term, *antidote*, in which the effect of one drug tends to neutralize the effect of another. Street people customarily depend on antagonistic drug effects to keep their desired effects within a controllable range. However, 2 – 2 does not equal zero; consider as an illustration the result of mixing a bottle of ink with a bottle of ink eradicator.

Dosage is as central to an effect as motive is to purpose. *Minimal dosage* is that calculated to be the least amount required to arrive at the desired effect and thus to minimize the hazards of adverse effects. A *toxic* dosage is that amount found to cause an adverse effect. A *lethal* dosage is that amount which causes death. A *maximal* dosage is the delicate estimate of the level just below a toxic or lethal dose, and is utilized where a serious problem warrants serious drug intervention (e.g., chemotherapy for cancer).

Justification of drug use, therefore, requires in addition to a particular benefit a sufficient awareness and weighing of its accompanying hazards to arrive at a competent decision concerning use. In athletics, the requirements for this judgment are compounded: the analysis of these effects must be task-oriented as well as clinically oriented. The clinical use of a drug for an athlete may render him ill-prepared to participate safely in competition. For example, before succinylsulfathiazole was selected for prophylactic use by the U. S. Olympic Team to minimize the threat of diarrhea in Mexico City, it was tested to see if such use would backfire by decreasing the performance capabilities of the user.

CONTROLS. The third essential of a drug abuse perspective is the matter of controls to protect the athlete from drug producers, drug practitioners, and himself. Three types of controls exist – laws, ethics, and education.

The law states that any new drug developed for human use must first undergo a period of testing under tightly controlled conditions. A reasonable and beneficial purpose must be declared; effects are carefully noted. Animal testing precedes human testing if any question as to safety exists. During human testing, only physicians who are registered in one of the approved controlled studies may use the drug until it is released by the Food and Drug Administration (FDA) as either an *over-the-counter* or *prescription drug*.

The *over-the-counter* drug (proprietary drug) is less potent and is reasonably safe. It requires no prescription. A drug is released as a

prescription drug if the balance between benefit and hazard is too delicate to leave to the general public's selection but is controllable in professional hands. As a prescription drug, it can be dispensed only after a physician prescribes it for clinical purposes *and for his patients.* The law and ethics of the medical and pharmaceutical professions are specific on this point. Whether a drug is over-the-counter or prescription, its advertisements can neither exceed its reasonably proven benefits nor disguise its reasonably proven hazards. If the hazards are not controllable or no clinical benefits can be determined, it is banned from use and becomes an *illegal drug* (contraband) if marketed.

We have laws to protect the consumer from inadvertent as well as frank misuse of drugs. But to turn to the laws or regulations for control of drugs in sports is a hazard in itself. To turn to the law (as to turn to drugs) is often to rely on it. To rely on the law requires faith in a definition of right and wrong that punishes the undesirable while not inhibiting the desirable. Carrying out this definition is too much to ask for those who make and enforce laws. What does a coach do, for example, when a young athlete is caught smoking pot with his buddies? If sports do have educational qualities, they are as important for those who make mistakes during their developmental years as for the student who does no wrong (or who does not get caught doing wrong). Let us emphasize that it is a dire mistake to confuse *discipline* and *rejection.*

A CONCEPT OF DOPING. What is needed instead of more laws is a more manageable concept for dealing with the drug problem. To athletes, the drug problem is two-fold: the community problem of "freaking out," and the sports problem of "doping." The latter problem can be more perplexing because:

1. To strive to one's fullest to win is fundamental to competitive sports.
2. The popular press, capitalizing on the public's intrigue with "reasons" for successful and unsuccessful strivings, periodically returns to an indiscriminate debate on doping.
3. The athletic trainer and team physician are known to have a number of items at their disposal that would qualify as drugs.
4. Indiscriminate debates on drugs lead to indiscriminate approaches to control and also confuse doping with many honorable practices in the field of sports medicine.

The problem of doping can be approached best by reducing its issues to a simple functional definition: *Doping in sports is the use of a prescription drug for other than clinically justified purposes.* This definition lends itself to manageable and defensible controls by law, ethics, and education, the same that are used for street use of drugs.

By limiting doping to prescription drugs, we do not have to confuse those allegedly giving unfair advantage with either the less potent over-the-counter drugs or with the illegal drugs. Since potency is necessary to cure or control a significant clinical condition, any benefit of over-the-counter drugs would not be an unusual enhancement but would be limited to minor problems, and then primarily related to the purpose to comfort in the sense of relief from nuisance aches and pains. The illegal drug is illegal essentially because it does not provide medicine with clinical benefits.

By limiting doping to prescription drugs, roles and responsibilities and prerogatives are defined clearly: Only a physician can provide such a drug to the athletes. By limiting drugs to purposes not clinically justified, the ethics of the physician can be scrutinized on medical as well as sports standards.

Drugs in Athletics

During the depression of the 1930s, when everybody needed a lift, someone wrote a paper about the marvelous effects of the protein of gelatin. For the next two generations of athletes, gelatin became a way of life. It was added to everything from orange juice to soup. It was sprinkled on shredded wheat the way wheat germ is today, and Jack Benny and Jello had a special meaning for many of us believers. We did not realize then that we were only taking our turn in the long line of hopefuls who, throughout the ages, had "found" the magic formula which would enable man to increase his physical and mental capacities. Gelatin had two great advantages over today's protein supplements—it did not do any great harm and it tasted pretty good. However, it did not improve anyone's level of performance!

Down through the years, there have been thousands of substances that have been "the answer" to improving performance. The hucksters who sold patent medicines at the turn of the century to improve whatever needed improving had their pharmacological counterparts throughout the ages. Today, the chemicals ingested, injected, inhaled, and applied to improve performances only differ in name and variety.

The interest and vigilance among responsible groups against drug abuse have not been lacking. What has been lacking is the determination by individual coaches to explain to their athletes the fallacy of looking to chemicals for achievement. Authoritative state-

"Most substances that are claimed to help performance are backed by 'experiments' or 'studies,' or 'testimonials' which fail to stand the tests of time and corroboration."

ments on drug abuses in sports are available from national organizations involved.[1]

In *Ball Four* Jim Bouton tells of a ball player whose father, a pharmacist, permitted him to take 500 pills of benzedrine, an amphetamine, to distribute among his teammates.[2] This type of insinuation that every athlete needs some drug to perform competitively is the sort of propaganda that the coach-educator has to compete against. One can see how this kind of thinking can influence a youngster who wears on his sweatshirt the same number as a famous athlete, who plays golf with endorsed golf clubs, or who uses a mitt that carries the signature of his idol. If he reads in the newspaper that his hero apparently is taking drugs, even if only aspirin, he can come to believe the story and to believe in the effects of the drug.

Then what? A coach can be very suspicious that an athlete is using drugs, but to do something effective about it is another matter. Likewise, the coach may suspect that a physician is providing drugs to an athlete without justification. To arrive at his own judgment, the coach must understand (1) the relationship between the medical justification of the drug and the control of its effects and (2) the role of the informed team physician in this regard. A candid talk between the coach and the physician may be helpful. The coach should then tell his athletes the facts about drugs and continue directing his efforts toward the control of ethics and continuing education in sports medicine for all those concerned.

Sports physicians who have devoted much of their practice to the needs of athletes have acquired considerable experience as to the advisability of drugs. The AMA Committee on Medical Aspects of Sports is composed of such physicians who collectively give objective guidance to coaches and other physicians with sports medicine questions, including those related to drugs. Conferences and courses on sports medicine for physicians have emerged from this committee and from related organizations such as the American Academy of Orthopaedic Surgeons and the American College of Sports Medicine. However, such courses are not necessarily relevant to the background and particular problems of the coach.

The key interest in drug use among athletes focuses on performance—sometimes on a return to a performance level, sometimes on

[1] Such organizations include the AMA Committee on Medical Aspects of Sports, American Association for Health, Physical Education, and Recreation, National Athletic Trainers Association, National Collegiate Athletic Association, British Medical Association, Federation for International Sports Medicine, and the Pacific-8 Team Physicians.

[2] Jim Bouton, *Ball Four* (New York: Bell Publishing Co., 1970).

an increase in performance level. Most substances that are claimed to help performance are backed by "experiments," "studies," or "testimonials" which fail to stand the tests of time and corroboration. For orientation, let us return to the four purposes of drug use and review the more common drug controversies.

PURPOSE: TO CURE. Causing no controversy is the shot of penicillin to rid the athlete of a streptococcal infection. The physician is accustomed to checking for a history of penicillin reaction before administering the drug, and the immediate return to performance is neither the purpose nor the effect. An injection of pain-killer, however, is another matter, and a look at its purpose gives perspective to its desired effect. A diagnosis of muscle spasm (trigger point) is consistent with a condition in which pain is localized outside of a joint. Since pain causes more spasm, a vicious circle is encountered, and a well-aimed needle into the muscle's "trigger point" with a pain-killer "cures" the condition. In a specific case, an athlete was diagnosed as having a spasm. Because it posed a deterrent to safe performance, the chance of adverse effects was controllable, and a physician administered the drug. The athlete's immediate return to performance was a clinically justified effect.

However, this illustration is not the same as deadening an undiagnosed injury or a joint injury for the purpose of returning an athlete to performance immediately. Considerable damage could be the result of such use of anesthetics. An anesthetic may be injected into an injured joint to lessen discomfort caused by syringe removal of excess fluid in the joint, but an immediate return to performance is not the purpose.

PURPOSE: TO CONTROL. After years of blanket medical disapproval, the youngster who is diabetic, asthmatic, or epileptic may now be able to lead an active life—including participation in athletics—because of drugs that help keep his condition under control. This use of drugs, however, requires close clinical control. The physician's concern is the response of the individual to the effect of the drug and the stress of the particular activity. Sports physicians have become sufficiently aware of factors of influence to enable a more liberal, individualistic approach to the control of an atypical youth's health through drugs.

Preventive medications and vaccines also qualify as drugs with the purpose "to control" (i.e., control of the spread of a communicable

disease). No athlete should participate without such protection against tetanus, diphtheria, polio, and smallpox. Vigilance is still required for occasional additional use of prescribed preventive drugs. A recent example is the case of a baseball pitcher in Los Angeles who became sick with infectious hepatitis. He was admitted to the hospital and given gamma globulin. His teammates were also given globulin and were quarantined for a few days. The disease was controlled; no other team member contracted it. However, a few years before, at an Eastern college, an entire squad suffered from infectious hepatitis. Gamma globulin thus became a legitimate sports drug in that it allowed athletes to continue to perform.

PURPOSE: TO COMFORT. While certain drugs are of proven medical value, their effects on the performance of athletes must be questioned in each individual case. This is especially true of drugs designed to comfort.

Prescription drugs with this purpose in sports include anti-inflammatories and tranquilizers. Properly used, anti-inflammatory drugs actually have curative or controlling implications because their comforting effects on injured tissue help to minimize further tissue injury caused by inflammation, swelling, or spasm. First aid and therapeutic use of ice are advocated for these ailments, but sometimes a more potent and precisely applied drug may be justified.

In this regard, tranquilizers present difficulties. The decision-making process is relatively easy for a team physician who works with older athletes of professional clubs because their behavior patterns and sports achievements are essentially established. For the younger athlete, beyond an informed understanding of the effect of tranquilizers (especially their duration and magnitude), the best approach is to examine the true purpose of the drug's use among mentally healthy athletes. No chemical can change a situational problem, and a nervous or upset athlete may be suffering from such a problem. The best way a coach can comfort an athlete is to be his friend and leader. The coach should tell the athlete that this is the way life is, that it is normal to be nervous when faced with a challenge, and that chemicals do not help one to face challenges.

PURPOSE: TO IMPROVE. The prime concern about "doping" is not so much the ill-advised methods of returning an athlete to performance as it is the methods used to improve performance. The term *ergogenic* covers this purpose. An ergogenic aid is one that is

supposed to increase the capacity of physical and/or mental effort. With the premium in sports on maximal performance, and the widespread indiscriminate exposure of whatever reasons people want to give to explain their performance, sports are natural fertile soil for claims for a wide variety of ergogenic aids.

Reversing such fads sometimes can be found to provide humor, as revealed by one team physician:

> *We had inherited an early pro football expansion team – everyone's castoffs – that had collectively brought to one squad all the vain reliances on ergogenic aids of the League. It took me two to three years of perseverance with the help of our athletic trainer to rid the squad of these assorted undesirable practices. For example, injectable vitamin B-12, a drug in this form, was expected by some at half-time. Vitamins B and C are water soluble, so any excess beyond that needed goes out in the urine and could not be utilized anyway. Several other players had to sniff an inhalant every time they came off the field. But I found a published article that showed that prolonged exposure to this inhalant drug caused a loss of taste, including beer. The habit was broken.*[3]

More serious is the prevalence of athletic interest in the ergogenic potential of amphetamines and anabolic steroids. The functional concept of doping (page 14) frees us from the annoyances of non-drug, non-prescription faddisms; thus our attention can be given to the potent drugs supposedly offering ergogenic qualities.

Amphetamine. An amphetamine is a prescription drug that acts as a powerful stimulant to the central nervous system. It has the ability to increase alertness, respiration rate, blood pressure, muscle tension, heart rate, and blood sugar. It also has the capacity to abolish a sense of fatigue, suppress appetite, constrict blood vessels, and dilate the pupils of the eyes.

Usually, its therapeutic purpose in medicine is either as a mood elevator for people who are psychiatrically depressed or as an appetite depresser in diet control, with the normal dose of amphetamine being between 5 and 10 milligrams in tablet form. In the mid-1950s, use of amphetamines by athletes to improve performance levels allegedly became widespread. In 1957, the AMA appointed a Committee on Amphetamines in Athletics, the forerunner of the current Committee on the Medical Aspects of Sports, to look into the matter.

[3] Personal anecdote related at the Mankato Symposium.

A survey conducted by the committee among athletes, coaches, and trainers revealed that only about 1 percent of the respondents were aware of, or knew anything at all about, the use of amphetamines. Apparently, sugar pills and vitamins were being popped under the umbrella title, "pep pills." Later, the American College of Sports Medicine conducted a similar study. The results showed that about 35 percent of the responding group knew something about the use of amphetamines. Whether the results reflected a trend in use or more awareness of use is not known.

Two research projects which emerged at that time received considerable attention. One involved giving amphetamine to various athletes (runners, weight lifters, and swimmers). The findings were that 70 percent of the athletes improved in performance after having taken amphetamine. While this study continues to receive national attention, it has been criticized widely by other researchers as having been poorly controlled and interpreted. The other research project concerned swimmers. About a half hour before they ran on the track and the treadmill, they were given amphetamine. Fifty of the subjects did not improve in performance, 3 showed slight improvement, and 1 showed an actual decrement.

Other studies began to appear. One used exhaustive bicycle rides on a bicycle ergometer. Amphetamine was given before the bicycle ride; no increase in performance was found due to the amphetamine. Another group of researchers similarly tested swimmers on a 100-yard sprint, giving them amphetamine 90 minutes before the swim; they found no effect whatsoever on swimming time.

Later, there was a study designed to interpret better the findings of the previous studies. Amphetamine was given two to three hours before performance to two groups of people—conditioned athletes and unconditioned non-athletes. Both groups were subjected to exhaustive treadmill running for time. It was a double blind study in that neither the researchers nor the subjects knew when a group was receiving the amphetamines and when it was receiving a placebo.[4] The subjects acted as their own control, running six different times, with a day's rest in between. Three times they ran on the drug and three times they ran on the placebo (randomly assigned). The design called for two runs (12 minutes apart) on each occasion to make the subjects exhausted. The curiosity was, "How will amphetamine affect a good athlete's performance on a second run when he is already fatigued?" If the purpose for taking amphetamines (to delay or negate fatigue) is valid, the result in this study should be

[4] A placebo is an inert or innocuous substance that has no effect on the body.

that the athlete would perform better on the second run. The findings were that neither of the runs was improved by amphetamine. Neither group of subjects, in the rested or fatigued state, improved in performance when on the drug. The study did show, however, that while amphetamines increased blood pressure and pulse rate, they also stopped those parameters from returning to normal readily during recovery. This could be, and has been, an adverse effect for some athletes.

A questionnaire was given to these subjects at the same time, asking such subjective questions as, "How did you feel today? Did your legs give out? Did you feel better or worse today?" The last question was, "Do you think today you are on the drug or not?" Interestingly, only a very small percentage of people guessed the correct answer to the last question. One subject guessed it because he thought his saliva had an odd content; another guessed it when he talked more than normally. One night, a subject called the health service assisting in the study and said, "You've got to help me, I can't sleep because of the amphetamine." A check showed that he had been on the placebo that day.

The real hazard of amphetamine is revealed by the death of cyclists abroad. Amphetamines suppress the alarm bell of the organism, so to speak, so that an athlete can push beyond his normal capacities because he does not sense the safeguard of fatigue. Fatigue sets in as usual, but the body does not sense it. Exhaustion results. When amphetamines combine with heat, the stress is more profound; they can produce a kind of heat stroke, precipitating cardiac failure.

Also of serious concern is the fact that amphetamine causes insomnia, which might lead to more drug-taking. Barbituates often become involved. In other words, if an athlete uses amphetamines to pep him up, he may resort to another drug, like phenobarbital, to slow him down, to allow him some sleep, and to keep him from becoming irritable. Not only can he get onto the vicious roller coaster of taking something to pick him up and then taking something else to put him back down again, he is also courting physical dependency, which is an effect of barbituate use that is not shared by amphetamines. (See chapter on Street Drugs.)

An in-depth review of all the research on the effects of amphetamine on human performance indicates that the action of amphetamines is not as much the lessening of fatigue as it is an improvement in sustained attention. This is a significant distinction. To improve performance *reliably* by amphetamines, three elements were found to be required:

1. existing sustained attention to the task
2. habituation to the task
3. habituation to the drug.

Consequently, to arrive at any ergogenic benefit via amphetamines with any reliability, the task must be sufficiently simple and uniform to permit sustained attention and habituation. Most sports tasks are complex and variable. Those athletes whose tasks might meet these criteria, moreover, must first guess correctly the timing and dosage to get the desired effect during performance. They must also paradoxically risk deteriorated performance from being habituated to the drug. Habituation to amphetamines can lead to insomina, headaches, acute anxiety, and, as mentioned earlier, circulatory collapse. One recent study on volunteers who took small oral doses of amphetamines daily found that paranoid psychosis (suspicion associated with delusion) developed in five days. After discontinuing use of the drug, they reverted to "normal" in eight hours.

Further, there is some evidence to show that many persons develop an increased amount of insulin in their bloodstream after taking amphetamines. Since an increase in insulin reflects an eventual lowering of blood sugar, a resultant drop in performance is to be expected.

Finally, and very significantly, research on amphetamines also suggests that a person's judgment can be impaired in the sense that it elevates mood, creating a feeling of confidence and power. This causes the user to overestimate the beneficial effect of the drug on his performance. This finding underlies the common impression among amphetamine users that the drug is helpful, an impression that interferes with educational drug programs.

Anabolic Steroids. In some sports, the addition of weight is considered ergogenic. The androgenic-anabolic steroids, prescription drugs, so named because they resemble chemically and functionally the male sex hormones, are being taken by some athletes with the intent of gaining weight for the sports where weight is assumed to be an advantage. Male (androgenic) hormones are produced primarily by the testes; testosterone is the principal androgen. All commercially available anabolic steroids share the properties of testosterone, which are: (1) growth stimulation, (2) acceleration of bone maturation, and (3) virilization. Androgenic-anabolic steroids may lead to increased weight; such is the anabolic effect. The at-

tempt to separate the anabolic effect from the androgenic effect has resulted in synthetic steroids. To date, however, evaluation suggests that androgenic and anabolic steroids are nearly identical in their effects when given in equivalent doses.

These drugs have been categorically condemned for athletes by medical experts; their hazards—although more subtle than those associated with pep pills—are considered potentially serious. Yet, because the beneficial effects are hotly contested and the hazards are subtle, this drug problem will probably haunt the concerned coach for some time to come. To illustrate, the anabolic benefits of these steroids make them clinically useful in the treatment of some anemias, osteoporosis of bone, and chronic debilitating illnesses as well as male hormone deficiencies. However, such use in children and young adults should be undertaken only after consultation with specialists in child growth and development because of the adverse effects being experienced. For example, prolonged use of the oral androgenic-anabolic steroids impairs liver function. Concern over its carcinogenic (cancer) effects—for example, cancer of the prostate gland—is advanced by drug companies in their list of precautions for clinically justified purposes.

A complete understanding of these drugs is necessary. There is open knowledge that key athletes in some sports use these steroids. The increasing number of testimonies appearing in the popular press indicate that such openness is in direct conflict with customary ethical deterrents to drug use. The "new ethic," as championed by these users, is "If it works, why not?" There is conflicting evidence beyond testimonial that these steroids have ergogenic qualities. There are now beginning to appear also some testimonials about the adverse effects of steroid use. The following item appeared in a May 1972 wire service:

> *A . . . lurid warning appears in the latest issue of the American magazine* MusclePower, *which debates the wisdom of taking steroids. George Kaye, the physiology editor, asks, "How nutsy must one be to risk liver damage, testes atrophy, prostate and kidney damage and potential cancer? They don't tell you about the Texas discus-thrower who's now neither a man nor a woman. Or a bald 14-year-old body-builder in Connecticut. Or the Arkansas shot-putter who will be dead by the time you read this. . . .*

Of special significance to this controversy is that the implications for the physically immature and mature athletes are not identical.

A young athlete who reads of an Olympic participant's use of these steroids should know these implications.

Puberty is generally considered to correspond with the onset of spermatogenesis and a sudden spurt in linear growth. Young athletes at the junior high or early high school level who take drugs often do so to gain height as well as weight. Linear growth (height) is made possible only by active growth centers (epiphyseal plates) near the ends of the long bones. These centers produce bone cells until maturation, at which time the centers disappear and the bones take on their permanent size. The steroid's effect on the acceleration of bone maturation ironically does not mean accelerated growth, but rather accelerated closing of the growth centers and consequent premature cessation of growth. Thus, prepubertal boys receiving the steroids definitely risk decreased ultimate height. In addition, premature virilization of boys in this age group occurs frequently, even at recommended dosages in clinically justified use.

In the *pubertal male*, where the growth spurt is essentially maximal for most (but not all), the use of these drugs has less effect on growth. In sports where inches count, the significance of any degree of such an effect cannot be discounted. Further, the regular use of steroids among boys in puberty has been found to suppress the developing testes' production of testosterone. Apparently, the body's regulatory mechanism senses it has enough androgenic hormone (from the steroid) and shuts down its production of the real thing. What this means to the maturing boy has yet to be determined.

For the *postpubertal athlete*, the growth and development factors do not generally apply; however, anyone who has been in sports knows of athletes who have continued to grow in college and even after college. This population may consider the drugs' side effect to which they are vulnerable—a decreased libido—sufficiently inhibitory. Testicular size and function are known to revert among some to the prepubertal stage during continued use in sufficient dosage of these steroids. These side effects are both contested by some, well known to others.

As is the case in all drugs, different individuals respond to anabolic steroids at different tolerance levels. The most significant effect feared from their prolonged use is the carcinogenic effect already mentioned. This parallels the increased statistical risk of breast cancer among women who increase their hormonal input via birth control pills or other estrogen treatments.

What do these drugs really do to healthy young athletes? Research findings offer little help. Fowler's study in Southern California on the effects of anabolic steroids on athletes revealed no

significant differences between subjects who received the drugs and those who received a placebo, with respect to strength, motor performance, work capacity, and other measurements. Johnson's study in Utah yielded beneficial results with respect to weight gain and strength. On both accounts, the number of subjects was small, and their reliance on short-term effects pose serious limitations as to their usefulness. Meriting special consideration in this regard are the ethics of human experimentation. Legitimate researchers are having difficulty justifying the use of a potent prescription drug to study an effect with no apparent clinical purpose.

The coach therefore cannot turn to dramatic and conveniently observable adverse effects of anabolic steroids to turn off an athlete who is afraid he will not be competitive without them. However, he should explain how drugs can upset the body's hormonal balance, which is an extremely delicate matter, and that any tampering with it requires the attention of a specialist in endocrinology. Since the purpose of taking anabolic steroids for increased athletic prowess is not clinically justified and since the steroids are prescription drugs, then the use of these drugs becomes doping.

There remains no rationale advanced for giving these drugs to healthy athletes of any age. The ill effects are insidious and not immediately apparent. The delay in appearance of unwanted effects can easily lead to misdiagnosis and inappropriate treatment. If these conditions are unconvincing, the legal and ethical implications cannot be disregarded.

CONTROLS. In the complicated situation of drugs in sports, the matter of controls must be considered. When did the government begin taking action? What does history tell us ?

Government Control. Legal experiences in sports drugs began in the 1940s when a supplier of athletic trainers' supplies and first aid preparations was reprimanded by the Federal Trade Commission (FTC) for excessive claims regarding germ-killing powers, prevention of certain diseases, liniment powers, increased energy, and similar pseudomedical treatments.

In 1961, the Food and Drug Administration (FDA) seized another company's food supplement as a drug being falsely promoted to coaches as an aid to increasing physical endurance, preventing fatigue, lessening muscle soreness, and improving physical efficiency. Seized at the same time was another product by this company labeled to improve resistance to bruising, bleeding, and colds. The FDA

charged that the product was ineffective for the conditions represented in the labeling.

More recently, in 1966, the FDA withdrew dimethylsulfoxide (DMSO) from its human trial status. DMSO is a chemical, a solvent by-product of the wood/paper industry. Its purpose in sports came from the discovery that it was a potent pain killer. If rubbed on topically, its analgesic properties were noted quickly (as was its cause of unpleasant breath). However, it is a potent solvent, and the athlete risked absorbing into his bloodstream toxic ingredients found in liniments, turf fertilizers, and line markers, as well as risking premature return to play by masking injury pain.

The problem with this so-called miracle drug was that popular publicity had jumped the gun on the evaluation of the drug in its preliminary testing. According to the AMA Committee on Medical Aspects of Sports, the resulting clamor for DMSO's sensational qualities and the easy access to impure DMSO brought pressure on physicians who (1) did not have the benefit of investigative reports that defined the hazards as well as the values associated with particular circumstances and patients and (2) would not have been using the drug ethically or legally unless in a registered study for one of the several sponsoring drug companies. Yet, even though DMSO was still restricted only to authorized clinical investigations conducted by registered medical personnel, and even though the drug had particular hazards for athletes, this did not hinder some of the officials of a drug firm involved from praising DMSO to coaches and trainers at sports meetings. The FDA removed DMSO from human testing shortly thereafter, due to changes detected in the eyes of laboratory animals tested.

A reasonable depth of search has provided only these three instances of direct government intervention in protecting athletes from drug manufacturers. This figure could be raised to four if one accepts the action by another country against an American-made product called "Strawberry Ointment"—because it contained no strawberries.

Doping Control. With research yet to discover a way to supercharge a normal cell, and government controls relying essentially on ethical conduct of health practitioners, the sports world continues to wrestle with laws against doping.

Sports history records many attempts at dope control, and until recently almost all of them were dismal failures. After a Dutch cyclist died in 1886 following a road race, it was determined that he had been doped by his coach with cocaine and heroin. (The coach also

made and sold bicycles of the brand name used by this unfortunate athlete.) This prompted the first attempts to control drugs in sports. The technique used at that time was the inspection of luggage and clothing. This accomplished nothing, and shortly afterwards, a physical examination was required of all athletes just prior to competition. This technique also failed. A combination of rules and regulations was then set forth by several sports federations, and this, too, did little or nothing to stem the tide.

In 1910, a Russian chemist discovered how to test the saliva of horses for certain drugs. Following this discovery and its use at the racetrack, doping in horseraces dropped tremendously. It is reported that in 1935 the Florida Racing Commission estimated that 50 percent of all racehorses were doped; by 1969 less than 1 percent were doped, indicating that dope control programs, when backed by scientific testing, do work – at least for horses.

With the development in recent years of additional biochemical techniques, namely, thin layer chromatography, gas liquid chromatography, and mass spectrophotometry, tools are available for the first time to identify a variety of drugs in humans. Urine has become the biological fluid of choice for examination and good doping control programs now examine the urine of every athlete in competition.

The simplicity of the functional concept of doping, as emphasized in this booklet (page 14), can be appreciated by reading the current definition of doping enunciated by the Medical Commission of the International Olympic Committee:

> *Doping is the administration of or the use by a competing athlete of any substance foreign to the body or of any physiological substance taken in abnormal quantity or taken by an abnormal route of entry into the body, with the sole intention of increasing in an artificial and unfair manner his performance in competition. When necessity demands medical treatment with any substance which because of its nature, dosage, or application is able to boost the athlete's performance in competition in an artificial and unfair manner, this is to be regarded as doping.*

There are countless other definitions advanced by sports groups and individuals, each having trouble with limits of inclusion and exclusion in the list of banned drugs. One reason for this difficulty is because many "banned" drugs sometimes do have legitimate uses in sports. Unhappily, most definitions seem to be based on the assumption that there is a magic substance that makes winners, and dope

control programs that test only winners tend to fix in the minds of everyone that doping and winning are connected. "But it ain't necessarily so." Let's look at the record.

In Winnipeg in 1967, of the eight positives in a dope control program conducted on cyclists, five of the positives were among the losers and three were among the winners; about the same number of winners and losers were tested. The definition of "winner" included anybody who placed first, second, or third in any of the heats up until the final race. In Rome in the same year, it was the cyclists who finished 11th and 12th in the road race who were positive for amphetamine. In 1968, 17 percent of all the soccer players in one Italian league were found to be using amphetamines. Most of them were on losing teams.

Even considering that in any given race there are only three winners, and often many more than that also ran, let us look at two dope control programs where the same number of losers and winners were examined. In the 1970 World Championships of one sport, a dope control program was carried out, and the following positives for amphetamine were found:

Table 1/Amphetamine Study—1970

Athlete Number	Place: 1st Event	Place: 2nd Event	3rd Event
First Day			
076	9th	18th	
049	12th		
Second Day			
087		15th	
068		26th	

Contrary to popular belief, amphetamines can be difficult to obtain for some, and caffeine is becoming increasingly popular as a stimulant. As a second part of the previous study, therefore, the caffeine levels also were obtained. The results are listed in Table 2.

From these results there appears to be no relationship between amphetamine or caffeine and winning. In fact, these figures seem to indicate that both have a poor effect on performance.

In a more recent national trial, every athlete was tested, the first time this was done in the history of sports. The program was unannounced, and the athletes were brought into the drug control

Table 2/Caffeine Study – 1970

Athlete Number	1st Event	2nd Event	3rd Event
First Day			
087		9th	
086		14th	
024	3rd	27th	
020		29th	
Second Day			
048	2nd	12th	
049	5th	10th	
046	10th	14th	
086		12th	
058	24th	13th	
076		22nd	
020	29th	30th	
021	31st (last)	30th	
Third Day			
068	18th		19th
076	20th		20th
086	Not ranked		Not ranked

room where urine specimens were collected after the day's competitions were completed. As soon as the word on the drug control program got around, one athlete decided not to compete; otherwise, cooperation was 100 percent. The results were of the 73 athletes tested, one was slightly positive for amphetamines; he finished 10th in one event and a poor 3rd in two other events. One was slightly positive for a tranquilizer; he finished 22nd in one event and 5th and 6th places in the other two events. One had an unknown alkaloid; he finished 6th place in both events in which he competed. All three finished in about the same places and times as they had in the practice sessions during the previous two weeks.

Contrast this type of program with the publicized happening at the World Weightlifting Championships in Columbus, Ohio, in September 1970, where eight out of the nine subjects who were tested in the first half of the competition were found to be positive for amphetamines. However, only those who placed first, second, or third in three contests were tested, and the winning places were given to those who finished fourth, fifth, or sixth without ever having tested them! One of the heavyweight lifters subsequently said, "It's ridiculous. Athletes in this sport have been taking ampheta-

mines under doctors' prescriptions for years." On the other hand, another individual who has been around the sport a long time – the U. S. Olympic Weight Lifting coach in Munich in 1972 – said, "Weight lifters get absolutely no assist from amphetamines. There were more records broken in the last half of the (Ohio) competition when all the tests were negative than during the first part of the competition."

As is well known to coaches, if a dope control program is to be used, it has to be highly structured, comprehensive, tightly enforced, and expensive. This would be justified only at the super-athlete level, and then primarily to protect the sport from cynical abuse. Not all drug analyses are accurate. Some drugs, such as anabolic steroids, are not detected in the urine. Also, not all of the urine tested is that of the athlete being tested.

Such doping control programs will remain necessary at championship level competitions as long as there is ethical laxity among coaches and team physicians. This is an expensive and time-consuming procedure, but it may be the only way the super-athlete will look ahead and train without drugs so that he will be competitively eligible when it counts.

Other tests will still have to be found, but the continuing evidence from current test results – that the users are among the losers – will help reverse the age-old image of the ergogenic drug.

PROTOCOL FOR A SPORTS DOPE CONTROL PROGRAM

1. Every contestant must be tested.
2. Every athlete must be positively identified.
3. Collection of his specimen must be witnessed by an incorruptible person.
4. The pH (scale for measuring acidity and alkalinity) of the specimen should be checked. If the specimen is alkaline, the athlete must be required to produce additional specimens until one is strongly acid. (Substances may be swallowed to negate detection of a doping drug, but the side effect is an alkaline pH.)
5. The specimen should be divided into equal parts, about 50cc in each of two identically coded bottles.
6. The athlete's name should be printed on the ledger, together with the appropriate code number, date, title of his event, time of collection of specimen, and the pH.

7. The athlete should attest to the fact that this is, in fact, his code number by signing the register. (It is rarely helpful, but always interesting, to ask the athletes at this time if they have taken any medication. The first answer is usually "nothing," but on gentle probing one can find an amazing list of vitamins and food supplements, etc.)

8. The coded bottles should be sealed and kept under lock and hand-carried by a responsible member of the dope control team to the laboratory where one half of the specimen is saved and the other half is analyzed by using the techniques of thin layer chromatography, gas liquid chromatography, mass spectrophotometry, and, if necessary, crystallography, to identify the substances.

9. If a positive specimen is found, the authorities in charge of the athlete and his competition should be notified. The athlete should have an opportunity to have an expert of his choosing follow the second half of the specimen through the same lab when it is checked. The second specimen should be checked in the same lab because, unfortunately, *any lab can turn in a negative.* The laboratory and medical section should report all confirmed positives and leave whatever action that is deemed appropriate to those in charge of the sport.

Street Drugs

INTRODUCTION. A great variety of drugs, in addition to those that supposedly increase athletic performance, await the curiosity of athletes. These are street drugs, and those who use them frequently are associated with the life style of the drug culture. The athlete, especially the young athlete, is found to be increasingly vulnerable to the street drug scene.

While the effects of drugs on behavior may provoke curiosity, the user's *purpose* in taking drugs is what merits examination. Authorities have given many reasons for drug use—for kicks, for escape, for the gang, for something to do, for rebellion. If the complex motives of behavior can be simplified, the essential motive of man is to seek pleasure—to select behavior that gives expectations of pleasure. As an infant, pleasure is connected with physical needs: to be fed, dried, cuddled. As a child, pleasure comes from new perceptual experiences, discovering oneself and the world with endless questions of "how come?" As a school-age youngster, pleasure begins to center on risk-taking behavior and social acceptance; one's ego develops through a feedback of what he feels that others think of him. As an adolescent-emerging adult, pleasure is related to putting it all together: the physical, perceptual, and social needs.

One of the highest compliments currently being voiced by youth is, "He has 'put it all together.' " This compliment appears to be reserved for individuals who experience pleasure, understand the

"Forcing the coach to ignore or turn in a boy who has broken the drug rule does not exactly contribute to a youth's need to share a problem with his coach at a crucial time."

up-down-real-unreal dimensions of behavior, are aware of their own patterns of response, achieve success by "staying up" in the real world, and are not hung-up or dependent. Viewed in this way, the business of getting it all together is not just a youthful or frivolous quest, but one of major concern to all mankind.

In athletic competition, getting it all together means that the offense and defense click on the same day. In the game of life, it means that the individual must get the financial, philosophical, religious, psychological, sociological, biological, pharmacological, and political aspects of his life together into a meaningful whole. Successful drug education also means bringing together all the complexities in a meaningful way.

Meaningful drug education is less concerned with analyzing the harmful effects of street drugs than discovering the motives that produce drug-taking behavior. Some of these motives are known to the person and some are unknown (subconscious); some are obvious and some are disguised. By enabling the person to examine his own motives, the effects of his behavior can be approached in a more constructive vein.

True pleasure comes from personally achieved fulfillment. The immature person, thus, can be considered one who has not put it all together, whose purpose is *immediate* pleasure. Such pleasure may be in the form of escape, kicks, rebellion, power; but the effect, like the purpose, is immediate and not long-lasting. Thus the immature person may seek repeated drug use to maintain a sense of pleasure. The irony, emerging from scientific study, is that *among the apparent effects of prolonged drug use is the inability to gain normal pleasures.*

Street drugs are commonly termed *mood modifiers* because they are used to cause a change in mood. Repeated pleasurable experiences with a particular mood modifier often lead to dependency on the drug, whether from the realization that other experiences no longer provide pleasure or from the fact that some drugs cause physiological changes in the body's cells and produce a physical dependency on that drug.

The World Health Organization's drug classification, Figure 1 (page 36), shows that the characteristics of drug dependency may differ from one group of drugs to another. For example, recall the previously mentioned problem of the athlete who, after resorting to amphetamines for "getting up," turns to barbiturates to "come down." In doing so, he is turning to a drug that causes physical as well as psychic dependency. In explanation, consider the meanings of the following words:

Dependency. *Addiction* and *habituation* are no longer preferred terms in describing drug action because their meanings have become ambiguous as the scope of drugs being abused has increased. Instead, the term *physical dependency* is used to describe a change in body chemistry caused by prolonged use of a drug; a cell comes to need that chemical for its internal metabolism. *Psychic dependency,* on the other hand, comes from a mental obsession with, or psychological reliance on, the mood modifying effect of a drug. A person dependent on drugs, either physically or psychologically, cannot function without regular use of the chemical. Different drug dependency patterns are found in different drug "families," as shown in Figure 1 (page 36).

Abstinence Syndrome. A person who is physically dependent on a drug cannot function and literally gets sick when use of that drug ceases. This "sickness" (abstinence syndrome) is the period during which the body must learn to readjust to the absence of that chemical. In popular language, this is going through "withdrawal," or "cold turkey." Not many realize that *withdrawal from barbiturates is life-threatening,* more serious than withdrawal from opiates, and thus requires medical supervision.

Tolerance. If a person uses a drug regularly, the dosage may have to be increased from time to time to get the desired effect. This is the phenomenon of tolerance. A heavy user may build up tremendous tolerance to a drug. Beyond the economic implications of tolerance (including the necessity for opiate abusers to commit crimes to finance their dependency) is the hazard of overdose. There are times, whether intentionally or otherwise, when a heavy user stops taking a drug for a period of time and then returns to its use. When he stops using it, tolerance is lost; consequently, if he resumes drug use at the previously tolerated dosage, he may be taking a toxic or lethal dose (i.e., he overdoses or O.D.'s).

Some drugs cause *reverse tolerance* – less of the drug is needed to get the same effect as on previous occasions. This occurs in regular use of a drug that is metabolized too slowly to be cleared from the body before the next use. Marijuana is now known to have a reverse tolerance effect.

Depressant/Stimulant. Mood modifying drugs can be classified as depressants or stimulants. The basis for classification is not by mood, but by physiological action on the central nervous system.

	Action	Psychic Dependence	Physical Dependence	Abstinence Syndrome	Tolerance
1. Opiates	↓	Yes	Yes	Yes	Yes
2. Barbiturate/Alcohol	↓	Yes	Yes (severe)	Yes	Yes
3. Cocaine	↑	Yes	No	No	No
4. Cannabis (Marijuana)	↑	Yes	No	No	Reverse
5. Amphetamine	↑	Yes	No	No(?)	Yes
6. Psychedelics (LSD)	↑	Yes	No	No	Yes
7. Tobacco	↓	Yes	Yes	Yes	?

Figure 1/Drug classifications (modified from the World Health Organization drug classification system).

Depressants (downers) slow down neurometabolic action; *euphoria* (mood of pleasurable well-being) comes from depressing mental or physical pain. Clinical uses of depressants are: as *analgesics* (for relief of pain), *anesthetics* (for dulling all sensation), *sedatives* (for relaxing mental and muscular activity), and *hypnotics* (for inducing sleep). A *narcotic* is a drug which does all of the above as well as lowers the sex drive and causes constipation.

The hazard of depressants, beyond causing physical dependence, is the possibility of overdose – the nerve pathways involved in breathing and other life-preserving functions become depressed as well as those related to mood.

Stimulants (uppers) act to excite the central nervous system. Euphoria comes from the kick, the power sensed when everything is fired up, and in the delight of bizarre psychedelic perceptions. The problems caused by stimulants include psychic dependence, the erratic interpretation of the effects of the drug on the user's perceptions, and the physical exhaustion from unduly prolonged activity.

Even with this generalized definition of stimulants, the significance of the user's *purpose* in taking the drugs can be noted. LSD and amphetamine are both stimulants, yet their use is usually determined by one's personality needs. A speed-freak (heavy user of amphetamines) seeks the flash or full body orgasm, an extrovertish quality which can pose hazards to others. The acid-head (heavy user of LSD) looks inward at himself through his drug, an introvertish quality which poses hazards primarily to himself.

There will be different dosage and psychological effect of an amphetamine if the purpose is to increase performance or get high. One's expectations are key factors in interpreting the resulting experience. The significance of the interpretation of a drug experience can be explained best by defining some commonly used words related to psychedelic drugs.

Certain stimulants are noted for their *psychedelic* characteristics. This merely means that the effect of the drug includes a magnification of sensory input interpretations. A whisper may be a shout. A flower may be a rainbow. It also means a lack of control over this interpretation. Sounds can be tasted. Colors may be heard. Patterns defy duplication.

Related to the term psychedelic are the psychological terms *hallucination* and *illusion*. Hallucination is the term given to sensory interpretation of a nonexisting thing, while illusion is a sensory misinterpretation of an existing thing. The latter should not be confused with *delusion*, a false belief or irrational logic. For example, if a drug abuser saw the devil standing next to you, that would be an hallucination. If, in his eyes, *you* appeared to be the devil, that would be an illusion. If he decided to jump out the window because he felt threatened by the devil or because he thought he could fly, that would be a delusion. These three terms are related to psychosis and neurosis.

A *psychosis* is a state of being mentally in another world, away from reality, "flipped." A drug "trip" is a drug psychosis—a temporary psychotic state which lasts until the effect of the drug wears off. Sometimes the user does not return to reality after the chemical effect is gone. Such a person is assumed to have had prepsychotic characteristics or to have interpreted the drug trip as being too close to reality, and thus too terrifying to accept.

A *neurosis* is a hangup that interferes unreasonably with living a full life. A *neurotic tendency* relates to the hangups we all have that bother us but can be shoved aside if necessary. For example, a fear of heights may be one's neurotic tendency. But an inability to enter an airplane, even though one's career requires it, reveals a neurosis.

The difference between good trips and bad trips lies frankly in the person's interpretation of his psychedelic experience. One "freaks out" if he interprets a psychedelic experience as "threatening;" another is enraptured if he interprets his experience as "beautiful." The saying goes, "One person's ecstasy is another's psychosis." Consequently, the person who has decided to have a psychedelic experience must not have underlying fear or instability. Further,

while "tripping," one must be protected by a "babysitter" from changes in the environment as well as from hazardous erratic behavior.

With this basic preface, the significance of Figure 2 can be seen. This visual model of street drug effects was created by John Burt of the University of Maryland. The advantage of this model is its graphic representation that the effects of drugs differ from one another and from any purpose connected with the world of the living.

THE FOUR-WORLD MODEL. When we look in on man trying to actualize himself and find happiness, the range of behavior observed is so great that simple classification appears impossible. Further study, however, reveals that man operates in at least four interrelated worlds: (1) the up world, (2) the down world, (3) the real world, and (4) the unreal world. Some examples will serve to illustrate this four-world model.

The Turned-Off (Down) World. Sectors C and D of Figure 2 are patterns of behavior that we might call "turning the world off." The curves range from simple diversion and relaxation, through a few alcoholic drinks, to sedatives, hypnotics, and tranquilizers, and on to the abuse of barbiturates, and opiates.[1] This pattern of response constitutes "going down." An example of the motivation that attends this response has been described by a heroin dependent in a newspaper article:

> *Man, when you shoot H, you're no longer in the ghetto. You are in your own world. You can't see rats. You can't see the roaches. You can't smell the garbage. You're no longer hungry. The holes in your shoes don't bother you . . . It's your own heaven, and you want to stay there . . .*

The Turned-On (Up) World. Pathways within sectors A and B of Figure 2 are behavior curves that we label "going up." Exhilaration can come from many sources, ranging from intense athletic competition and other exciting diversions such as sky diving, through viewing of violence and on to abuse of amphetamines.[2] Clement's

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[1] Probably the most frequently abused barbiturates are Seconal (Seccy, Red Birds, Red Devels, or Pinks), Amytal (Blue Angels), and Nembutal (Yellow Jackets, Yellows, or Nimbies). The opiates include morphine, methadone, and heroin.

[2] This class contains many drugs, but the three most popular appear to be Benzedrine (Bennies), Dexedrine (Dexies), and Methedrine (Speed, Meth, and Crystal).

description of the reaction to injected amphetamines illustrates the pharmacological expectation:

> *At first, activity is purposeful. There is marked loquaciousness, decreased ambivalence, a sense of cleverness and "crystal-clear" thinking and an "invigorating aggressiveness" during the early phases of the "amphetamine run." With time, activity becomes less organized. It may become compulsive, repetitive, and grossly disorganized. The initial relief from anxiety from what others feel or think may soon be replaced by suspiciousness and self-consciousness.*

The up-down continuum is a very popular one, reflecting the preoccupation of Americans with chemical control of emotions. The contemporary expression, "Give me Librium (a tranquilizer) or give me Meth (an amphetamine)," represents the two ends of the continuum. Historically, this continuum has served as the most frequent motivation for drug abuse and probably will continue to do so in the future.

The Unreal (Way-Out) World. Sections B and D in Figure 2 represent behavior patterns that we might label "moving into the unreal world." These patterns range from TV-Disneyland-Las Vegas fantasies, through personal withdrawal or dropout to use of the psychedelic drugs,[3] and in some cases, to total loss of contact with reality. The motivation for this behavior appears to be a "search for a world that is better than the real world." The implied assumption is that "somewhere, a world of loving, sensitive, and aware people exists." Hence, the real problem of life is to find this world and run away into it. The preoccupation is with finding, rather than creating, such a world.

The Nitty-Gritty (Real) World. Sections A and C contain the behavior patterns that identify with "coping with the nitty-gritty." This behavior is motivated by the belief that happiness results only from productive and creative effort and cannot be a quiescent possession. This principle was expressed by Aristotle many years ago:

> *And, as in the Olympic Games, it is not the most beautiful and the strongest that are crowned, but those who compete . . . those who act, win, and rightly win, the noble and good things in life.*

[3] The commonly abused psychedelic drugs include LSD, psilocybin, mescaline, STP and marijuana.

Two former drug users coming out of the unreal world and into the real world described their motivations this way in the *New York Times:*

> *Dope got to be all that was going on. All we talked about were prices, where the next shipment was coming from, who got busted. Dope is a very finite topic. It isn't at the heart of anything; it's just stuff.*
>
> *Drugs seemed to demand that I become totally disengaged from society and try to create a utopia, but I couldn't abandon the problem I saw all around me. I felt it was important to try to change nitty-gritty issues.*

Getting It All Together. Staying high in the real world is the unique accomplishment of those who "get it all together." But for most of humanity, life is like a yo-yo—up and down and in and out of the real world. For the latter group, life is attended by the constant question, "How do I get up and stay up in the real world?"

In the business of getting it all together and staying high there is probably more to be learned from the drug scene than most people realize. For example, one of the early leaders of the psychedelic movement, Richard Alpert, has aptly described a first principle of staying high:

> *I think LSD is making itself obsolete. All acid does is show you the possibility of another type of consciousness and give you hope. But your own impurities keep bringing you down. It's a yo-yo phenomenon—getting high and coming down. After a while you dig that if you want to stay high you have to work on yourself.*

"Getting it all together" requires working on one's self—that is, coming to understand personal transportation problems in the up-down-real-unreal worlds and mapping out a clear route to a carefully chosen destination. Figure 2 is a model designed to assist those who are still searching for direction. The model attempts to describe and contrast nine different systems of mental transportation.

Nine Frequently Traveled Routes. Routes three through nine of Figure 2 are pharmacological routes. Route three describes the response to barbiturates—going progressively down and with large doses into the unreal world. Heroin, route four, is another escape road. It is more attractive to many because, in addition to turning off the real world, it promotes a sense of well-being in the unreal

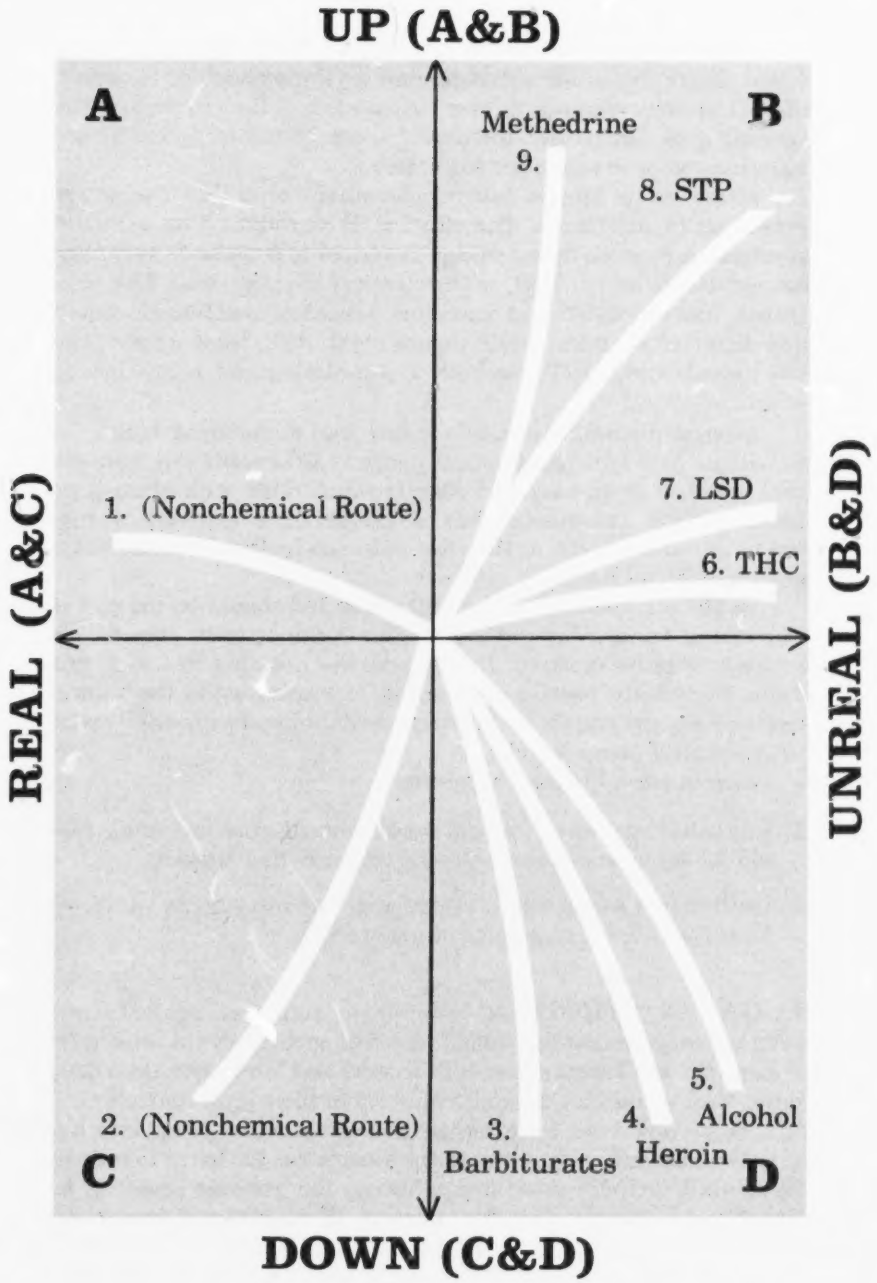

Figure 2 /The four-world model.

world. Route five is somewhat like routes three and four. However, alcohol in large amounts or over long periods of time may move the traveler even further into the unreal world. For example, hallucinations may occur in rare cases with alcohol.

Route six is labeled tetrahydrocannabinol (THC), the active substance in marijuana. The effect of THC ranges from a mildly psychedelic reaction in low dosage to a tripping reaction in very high dosage. Route seven, LSD, is the classical tripping drug. This substance, like psilocybin and mescaline, takes the user into an unreal and distorted chemical world. Route eight, STP, leads up and into the unreal world. STP has both a stimulating and a psychedelic effect.

Methedrine, route nine, is a widely used stimulating drug.

Route two is a nonchemical pathway that leads down in the real world. It is an easy and often-traveled route with many dangerous pitfalls. Travelers on this route often have no justifiable reason to like themselves, or they feel put-upon by the world, unlucky, or they suffer ill health.

Route one leads up in the real world and should be the aim of everything termed "educational." This route is open only to the active-productive-creative; the passive are not able to travel this route. Chemicals, passive excitement, or meditation in the wilderness will not get you there. You must come out and successfully cope with the nitty-gritty world.

In summary, Figure 2 suggests:

1. One cannot get up in the real world unless he has justifiable reason for doing so and subsequently comes to like himself.
2. Until one is successful in coping with the nitty-gritty world, he has no justifiable reason for liking himself.

LEGAL CONTROLS. As in sports, legal controls against street drug use must persist but cannot be relied upon as a solution. Figure 3 identifies the substance of both federal and Minnesota state drug laws. Most states now are quite uniform in their legal controls.

These new laws have reclassified the problem drugs into five separate schedules according to their potential for harm to society. Schedule I includes those drugs having the greatest potential for abuse and no accepted medical purpose. The additional four schedules cover drugs having a decreasing potential for abuse and increasing potential for justified medical use. In previous legal codes, narcotics control, amphetamines, barbiturates, and pharmaceutical

regulations and rules were classified in separate chapters, sometimes overlapping, sometimes not really making much sense. Much confusion resulted from such inconsistencies. The new laws cover the fields of pharmacy and pharmacology, except glue and alcohol. Further, they allow for a system of updating and changing the schedule of certain drugs when indicated.

In dealing with drug laws, the prosecutor and the police are faced generally with three concerns. The first relates to the illegal manufacture, sale, or barter of a drug. The prosecutor and police need to demonstrate possession of the drugs *with intent* to commit one of the above acts.

The second concern involves possession of a controlled substance without authority. The statutes give doctors, veterinarians, dentists, pharmacists, nurses, or someone under their guidance the authority to handle prescription drugs. However, anyone not authorized by the statute would be liable to prosecution.

The third concern involves an individual obtaining by false representation any substance which is prohibited by the drug laws. In this category would be falsification of a prescription or an invoice that is used between a drug house and a pharmacist. Penalties now take into consideration the schedule of the drug (e.g., whether it is a narcotic or a controlled substance), the previous record of the person involved, the age of the seller or buyer, and other factors.

HIGH SCHOOL DRUG RULES. State high school athletic associations admittedly and understandably have difficulty stipulating appropriate rules against drug possession or use among high school athletes. The street drug problem is sufficiently rampant at enough secondary schools that a number of athletes can be expected to be involved. A few states have definite rules of ineligibility for drug users, but the vast majority leave the drug ineligibility rules and decisions to local school systems.

There are advantages and disadvantages to both approaches of governance. The system involving state-wide rules has the convenience of uniformity and consistency; but it does not permit flexibility in handling individual cases. If high school sports are to be defended on their relevance and motivational merits, it must be recognized that a boy with problems often needs to stay with the team and be given the chance to redemonstrate his personal integrity. *Forcing the coach to ignore or turn in a boy who has broken the drug rule does not exactly contribute to a youth's need to share a problem with his coach at a crucial time.*

SCHEDULE	DESCRIPTION OF DRUGS	EXAMPLES OF DRUGS
I	High abuse potential. No accepted medical use. – NARCOTIC –	Heroin
	Same as above, but – NONNARCOTIC –	LSD Mescaline Marijuana
II	High abuse potential. Medical use. Severe dependence. – NARCOTIC –	Opium Codeine Methadone Morphine
	Same as above, but – NONNARCOTIC –	Amphetamines
III	Less abuse than I & II. Medical use. Moderate dependence.	Certain Barbiturates
IV	Less abuse than III. Medical use. Limited dependence.	Barbital Phenobarbital Chloral hydrate
V	Less abuse than IV. Medical use.	Cough-medicine-codeine Paregoric

Figure 3/New federal and state drug laws (unofficially paraphrased by Kenneth Clarke, Mankato State College, August 1971).

[1] P.L. 91-513, enacted 10-27-70; effective 4-27-71.

[2] Minnesota L 1971, Ch. 937; effective 6-8-71.

[3] If sold or distributed to a person under 18 by a person at least 3 years his elder, the penalty is doubled.

[4] If a first time conviction, defendant may be placed on probation. If satisfactorily completed, the court may expunge the public record of the proceedings (a nonpublic record will be maintained by the public safety department).

[5] For "small amount" Marijuana only: 1 yr. + $5,000 (If 1st offense, under 21: 1 yr. probation; if completed, record of arrest is expunged).

[6] For "1.5 oz." Marijuana or less (Not in resinous form): 1 yr. + $1,000.

[7] One or more nonnarcotic ingredients must be present in sufficient proportion to give the compound valuable medicinal quality other than those possessed by the narcotic ingredients alone.

PENALTY: NEW FED. LAWS[1]		PENALTY: NEW MINNESOTA STATE LAWS[2]	
Manufacture, Sale and Distribution[3]	Possession	Manufacture, Sale and Distribution[3]	Possession[4]
1st: Up to 15 yrs. + $25,000 2nd: 1-30 years + $50,000	Up to 1 yr. + $5,000	1st: Up to 15 yrs. + $25,000 2nd: 1-30 years + $50,000	Up to 5 yrs. + $5,000
1st: Up to 15 yrs. + $15,000 2nd: 1-10 years + $30,000	Same as Above[5]	1st: Up to 5 yrs. + $15,000 2nd: 1-10 years + $30,000	Up to 3 yrs. + $3,000[6]
Same as I – NARCOTIC	Same as I	Same as I – NARCOTIC	Same as I – NARCOTIC
Same as I – NONNARCOTIC	Same as I	Same as I – NONNARCOTIC	Same as I – NONNARCOTIC
Same as I – NONNARCOTIC	Same as I	Same as I – NONNARCOTIC	Same as I – NONNARCOTIC
1st: Up to 3 yrs. + $10,000 2nd: 6 mo.-6 yrs. + $20,000	Same as I	1st: Up to 3 yrs. + $10,000 2nd: 6 mo.-6 yrs. + $20,000	Same as I – NONNARCOTIC
Up to 1 year + $5,000	Same as I	Up to 1 year + $1,000	Up to 1 year + $1,000

The lack of uniform rules, while providing flexibility, has its limitations as well. Many coaches do not trust the coaches of another school to handle a drug problem objectively. They fear that other coaches will not be handling the drug problem professionally, let alone correctly. The best compromise will forever be an informed and concerned coach who will honor his professional commitment to youth through sports.

The Coach as a Counselor

In many communities, school-age boys and girls, athletes included, are already involved in some way with drugs; in most communities, there is no problem with opportunity. The adult community, the so-called establishment, has been playing a minor role in the effective counseling of drug abusers, at least according to the users' point of view. If a drug user has a problem, the person he usually will seek out first to talk to is another user, another young person, one of his peers. It is only when the situation gets out of control that he may seek help from a physician, a teacher, or a coach. This is largely because he simply has not been shown a reason to look for an adult he can trust.

Coaches are in a particularly good position to be excellent drug counselors. They have a great deal of contact with people under functional circumstances. The high school counselor has some contact with students in his office, but primarily at his own initiative and schedule. Many teachers do not get to know a particular boy or girl very deeply in the personal sense. A physician sees a boy once or twice a year, at most. However, a coach who has built up rapport with his students in real-life contexts is both exposed and accessible to concerned students; the student and athlete come to know the coach and vice versa.

There are a number of barriers, however, to this relationship. One of the key problems in dealing with drugs and the athlete today is that coaches have not been involved with drug counseling programs. The drug scene and sports rules have excluded the coach from a primary role in dealing with drug users. The coach who

"Do not confuse discipline with rejection."

wishes to become involved with counseling will find that his concerns can be viewed in four classifications of problems.

1. *The legal problem.* Many concerned coaches and teachers are afraid to become professionally aware of the problems of a drug user because they fear the legal implications. Do I throw him off the team? Do I tell the principal? Do I tell the police? Do I talk to the boy? The legal point of view causes a great deal of anxiety and promotes inconsistency in dealing with these situations. Because of school and athletic rules, many coaches *must* remove a boy from athletics or get him expelled from school if they admit they know that drugs are involved. This is known to both the coach and the athlete and does not create a good situation in which to start counseling when it is needed, early in the development of a problem. The resources for the person with a drug problem are cut down significantly if he must confine his concerns to his peers because coaches have cut themselves off or have been cut off from availability.

2. *The information problem.* As brought out in the first chapter, most coaches are uncomfortable in starting a drug counseling situation because they know little about drugs. Other than alcohol and tobacco, their drug experiences are nil. Their vocabulary is insufficient, perhaps obsolete. How can a coach who is accustomed to knowing more about a subject than his athletes, keep his position of authority and still relate effectively to youngsters who appear to be very sophisticated about drugs? This presents another form of anxiety among athletes and coaches that hinders the counseling process. Figure 4, however, gives guidance to concepts in chemical abuse education that appear relevant at different age levels.

3. *The attitude problem.* By forming too absolute an opinion on drugs and coming down too hard on people who use drugs, the coach puts the student in a position where he may not want to come to him. Ironically, this is particularly true if the athlete respects his coach and holds him in very high esteem. He does not want to come and say, "I'm having a hassle with drugs" if he thinks this is something which will cause the coach to hold him in low esteem.

4. *The "problem" problem.* A problem, like beauty, is in the eyes of the beholder. A youth who has not come to the point of telling himself that he has a problem, simply has no problem. Also, what a youth considers a problem may, in the coach's eyes, reflect a different and perhaps more profound problem.

	–1–	–2–	–3–	–4–	–5–	–6–	–7–
Concept	Maturity is dealing with situations realistically and effectively.	Respect for self in changing society comes from within.	Personality is a composite of one's total current being	Everyone experiences conflicts in life.	Personal values emerge from various influences.	As responsibilities change, consequences of behavior change in significance.	Well-being of a person requires rules within society.
Subconcept	Following the crowd can be dangerous.	You are an important person.	Self-defense mechanisms can lead to use of chemicals.	Personal frustrations are a part of life.	Influences early in life can affect the future.	Hazards are posed by use of chemicals.	Research, rules, and rehabilitation protect society.
Suggested Activities — — — Primary Grades	Use "just suppose" stories, such as being offered an unknown food by a playmate.	Discuss meanings of habits, good and bad.	Discuss drug dependency: illness vs. crime.	Give reasons why you are glad and why you are mad.	Discuss why chemicals are used by young people.	Display labels from cleaning fluids and discuss.	Discuss reasons for a physician's prescription.
Intermediate Grades	Dramatize being urged to take a drug.	Write on "What I want to be."	Discuss dangers of combining or sharing drugs.	Discuss "When I wanted something but couldn't have it."	Discuss advertising slogans and their purposes.	Collect articles on poisonings and other drug problems.	Discuss differences between stimulants, depressants, & hallucinogens.
Junior High Grades	Write on "Acting My Age" (what parents, peers, and I expect of me).	Review common ways to modify mood (tea, coffee, coke, sports, drama, music).	Discuss rehabilitation processes such as Synanon, Drug-Top-Lodge, etc.	Role-play showing emotions as baby, preschooler, grade schooler, teen, and adult.	Discuss ways drugs are used by MD's, teachers, addicts, athletes, hippies.	Relate chemical abuse to VD, infection, malnutrition, car accidents.	Report on drug research and thalidomide, Salk vaccine, LSD, and methadone.
Senior High Grades	Discuss community services and how they help people with problems.	Discuss emotional needs of all persons.	Role-play various defense mechanisms as reactions to chemical use.	Take inventory of gripes that cause hate, fear, jealousy, depression.	Analyze advertising of drugs in magazines.	Hear personal experiences of former users.	Discuss federal and state laws.

Figure 4/Abridged illustrations from Minnesota Department of Education Resource Unit on "Chemical Abuse Education" by Kenneth Clarke, Mankato State College (August 1971).

The coach, therefore, must get past the legal, information, attitude, and problem judgment barriers to develop a perspective of professional counseling to help meet the needs of his athletes. But it is worth the effort.

One of the easiest ways to handle a concern is just to avoid any contact. If a coach thinks the person is using drugs, he may just avoid the issue. He may attempt to open the channels of communication, or he may not make himself available. Why? If he does make himself available, what does he do?

The best way to get or keep a person off drugs is to get him on to something else. Athletic programs are very often this "something else," especially during adolescence when there is an abundance of energy. Consequently, youth athletic programs have a good thing going – preventive medicine. It follows that throwing a young athlete off the team – which may be the one thing that is holding him together – is just as hard to justify as keeping a young athlete with drug problems on the team, which may ruin the morale of other team members. This dilemma was voiced by a former athlete and drug user in a letter after the Mankato Symposium:

> *The ex-addict is customarily viewed as public exhibit number one and his experiences as confirmation of the myths and stereotypes associated with the "junkie culture." If we are to associate anything, however, it must be the ex-addict's experience with the prevailing attitudes toward youthful drug abusers and the methods of coping with the problem.*
>
> *For some individuals, the football field, basketball court and track course are, during their formative years, their way of life – a means of realizing the American Dream. Athletics constitute for them a potential career in a society where one's worth is measured by the ability to achieve. Whether the individual's goal be a hope of an engineering degree or a contract with the Boston Celtics, the principle is the same.*
>
> *This is why I know where the athlete is at who comes home from school and breaks the news to his family that his career is shot because he was discovered in the toilet with of group of other fellows when, in the words of the principal, "the place reeked of the odor of pot." This is why I relate to the conscientious student who took the "upper" in preparation for finals or the guy who was so turned off by his six-month drug run that he sought help from a teacher who, not knowing what to do, set the machinery in motion which resulted in his explusion from school and subsequently led him to "find an alternative life style" in the subculture.*

It's really a sad affair and a direct indictment of a society that condones, perpetuates and almost glorifies drug use and, on the other hand, severely punishes it.

I can relate to all of this because I've been there and back.

In the late 50's, I was considered one of the most promising athletes in the Chicago Public School system, competing at the time with men like Willie (The Bird) Jones and Emmet Bryant, all who later went to the pro ranks.

From my first game as a high school soph I maintained a 26-point average. Incidentally, I wasn't a scheduled regular until after that initial performance. Later I was to be honored in my senior year with a scholarship to Iowa University.

A lot of things happened that year. I got turned onto grass and pep pills, and when I was caught in the "pot filled washroom" – goodby scholarship, school, and future. It shouldn't have happened. I concede my fault and have damned myself a thousand times over the years. But along with this goes a personal indictment of a system that not only said, "I don't care," but was also responsible for making a criminal out of a youth who, if anything, needed a new hope, a new faith, a new start.

I've been asked at five different seminars if being reached at that point would have made a difference, if the ultimatum of "future or no future" would have been presented. The answer is an unequivocal yes and for those who would question it, I need only ask "was the alternative rational and just?

Thousands of kids are in jails right now with problems so like my own that you can't tell the difference. Over half aren't delinquents, haven't committed any crimes against persons, and have had the same hopes of a future that I had. They're not delinquents, but in that environment, believe me – they'll learn fast. We've been hung up on using punitive measures to deal with addiction and school-centered drug problems because most teachers do not know what to do. . . .

My position is that we look at our own attitudes and if they're biased or detrimental – change them. Offer alternatives to youth with drug problems, and the alternatives to the adults they trust will appear.

To gain this counselor perspective, we must return to each of the problem areas – legal, information, attitude, and problem judgment – and consider the essential concerns of each.

THE LEGAL PROBLEM. Through his various contacts with students, a variety of situations await the coach who is sensitive to opportunities and obligations for individually appropriate responses to professional tasks. Some of these situations are: suspecting that an athlete may be under the influence of drugs in class, hearing from parents that they suspect a drug problem beginning with their son – your athlete, being told by a student that he wishes to inform on other students who are using drugs, coming upon athletes in the act of drug use, receiving an individual who comes in and tells the teacher that he is using or experimenting with drugs.

The coach has an obligation to fulfill his duty to the community, the governing athletic association, the students, and himself by responding with reasonable principles to each of these situations. The coach knows that the abuse of drugs is illegal and that in order to maintain the standards of both sports and society, these laws have to be honored. However, if the coach knows of any drug abuse, he must proceed in a manner that will have the least detrimental effect on the individual as well as the community.

To perform these duties, the coach wants to know what his responsibilities are and what his capabilities and limitations are in meeting them. Some of the responsibilities may be in conflict with his own perceptions of certain ideals and personal wishes. First, the coach has to sense what is "right." Before he can believe that what he is doing is right, and in the best interests of the community and the individual involved, he must have a good "feel" of the particular situation. For example, if he accepts an involuntary encounter and the trust of confidentiality from the student, he may be hurting unwittingly that individual if he obtains information that may be harmful as testimony in a court of law. Yet, if he tells the person at the moment of encounter, "I may have to tell all of this information in court; you had better see someone else," he will have lost a precious moment for reaching someone who would otherwise be unreachable.

Legal involvement through a drug counseling encounter, however, is very rare; in fact *there is no recording of a counselor, teacher, or coach having been subpoenaed to court to provide testimony on a conversation with an individual concerning drugs.* Exposing the student to the laws, preferably before a crisis, is nonetheless important in that the student should know what may take place if the authorities take action against the coach and/or the student.

The key, perhaps, is the concept, "act in good faith," which has in common a legal and professional understanding. To act in good faith, the coach has to be alert to legal implications of a drug coun-

seling encounter, and to weigh these against the counseling opportunities of the encounter.

Fear of the law is of secondary importance to the student if the coach can be trusted to use his judgment in good faith and to refer the student, if necessary, to someone he knows who can handle the problem well. Acting in good faith also means that as counselor, the coach should know his own limitations. Possibly, the student merely needs someone to talk to. Then again, the situation may be more involved, and the counselor may have to utilize his trustworthiness to convince the student that someone else is better equipped and equally motivated to help him. If the coach is a listener, he will sense that he does not need all the facts to give advice and/or acceptance. This requires a fine sense of timing as well as understanding on the part of the coach. Any hesitation or verbal warning would jeopardize the student's willingness to obtain needed conversation.

Ideally, the coach should go over the legal considerations with his athletes long before counseling encounters take place (e.g., at the first squad meeting). This would minimize the hazard of being exposed unnecessarily to information that could be relevant to court proceedings.

Confidentiality and Privileged Communication. A key principle for a professional educator is to keep personal information about individuals confidential. This is an ethic, not a law. Privileged communication, on the other hand, reflects a formalized, legal confidentiality protected by the courts for a specific few: a husband or wife in testimony against each other; a lawyer, physician, surgeon, dentist, clergyman, or public officer (unless there is consent on both sides); people intoxicated at the time that they are required to be in court for examination; and children under 10 years of age who seem incapable of receiving accurate impressions of the facts or of relating them truthfully. These people either have privileged communication or are not considered competent witnesses.

Thus, every person of "sufficient understanding" (which obviously includes coaches) may be asked by the courts to testify in a civil or criminal action or proceeding involving information learned during the counseling encounter.

The Subpoena. A subpoena is a lawful writ issued to compel an individual to appear as a witness at a proceeding. The criterion that leads to a subpoena is very simple: if a lawyer thinks that an individual has information pertinent to a court proceeding, he can have the clerk of the court draw up a subpoena and have it issued to

this individual. A lawyer acts in good faith in that he believes that the individual has information that will be meaningful to the legal proceedings.

The coach who is reluctant to testify in court concerning knowledge gained from a counseling encounter is subject to being subpoenaed for this purpose. If an individual is issued a subpoena, he must be present at the designated time and place or can be liable for *contempt of court* which has various penalties.

If the individual attends court but does not want to testify, he can plead the Fifth Amendment. However, immunity under the Fifth Amendment will be based on the judge's opinion as to whether or not the individual will be jeopardizing *himself* if he testifies.

Hearsay and Excluded Evidence. The coach who does not wish to disclose the nature of a counseling conversation does not need to compromise his principles or subject himself to a contempt of court ruling. The rules on *hearsay* and *excluded evidence* provide legitimate opportunities to act in good faith. The hearsay rule provides the opportunity to withhold information received in an encounter that was not first-hand experience. A coach, for example, could not be asked to tell in court what the parents told him about an illegal occurrence involving their child. This would not hold up in court unless the student testified. Further, a witness cannot be led to prove the occurrence of an event by testifying that another party had told him of the event.

Excluded evidence is information from a conversation that is excluded in court by the presiding judge. If it is shown that people participated knowingly in a professionally confidential conversation, the judge has considerable discretion in protecting witnesses against being compelled to disclose such confidential information. Such testimony is usually given at the witness' request in the judge's chambers before the two attorneys and the judge. If the judge feels that the possible injury of such testimony would outweigh the benefits, or where an improper use would be made of the information disclosed, (i.e., it would be unnecessarily harmful to the various parties involved or to the community at large), he will permit the witness to withhold that conversation from his testimony. The recourse of excluded evidence is one that provides the best protection for the coach and student acting together in good faith.

School Policy. Regardless of courtroom technicalities, the coach should know exactly what school policies apply to drug counseling encounters so that when a situation arises, he can proceed in good

faith. If he feels that a current school policy is not appropriate for the circumstances of a particular case, he may elect to act otherwise. But he also will have to be prepared to defend his good faith and account for his actions. Ideally, deficiences in school policies should be examined and rectified before the emotions of a particular episode produce expedient action.

THE INFORMATION PROBLEM. As a drug counselor, a coach does not need a phenomenal amount of drug information. He probably will not have any more information on street drugs than his athlete, no matter how many books he reads. The student has probably heard more than the coach has; plus, he may have used the drugs. Consequently, the coach does not need to become more of an expert on drugs than the individual.

Drug information is not too important because a coach's role is not to deal with a drug problem, but to deal with a *person* having a drug problem. What is really important is the interaction between the coach and the individual athlete, not the coach and the drug. The appearance of the chemical, its name, or its effect on the blood pressure are helpful to know; but this type of information is not what a youth is coming to a coach to get.

What the coach does know is the distinction between the student's purpose in using drugs and the effects of the drugs on the student, and he can begin conversation at that level. It is also helpful to understand some basic concepts related to the prevention of drug abuse. Figure 4 (page 48) has digested the principle concepts and suggests educational activities for respective age groups that relate to these concepts.

Emergencies. The one area within drug abuse requiring some accurate information by the concerned coach is that involving emergency care. A coach who becomes known as being "with it" may inherit an occasional encounter—by telephone or in person—with a drug abuser in distress (having a psychological reaction (bad trip) or a physiologic reaction (overdose).)

Advanced first aid and emergency care education are coming to grips with these concerns, and the coach should learn the recommended principles and practices. Preferably, he should learn also from those in the community actually handling drug crises.

In handling "bad trips," for example, a key first aid ingredient is projection of calm, confidence, and respect. The three main objectives are to (1) get the person to relax; (2) change his mood to one of

emotional security; and (3) help him sense he can control his coming down to a supportive environment. The coach who by obligation must accept such an encounter should seek the help of a drug counselor at the earliest convenience, but not at the expense of these objectives.

The overdose is another type of problem. A coma or stupor related to drug abuse must automatically be considered a medical emergency; counseling is not the problem. Usually, this means an overdose of a depressant drug: barbiturates, opiates, and alcohol, by themselves or in combination. The key ingredient in this regard, other than haste in obtaining medical attention, is oxygen. These drugs in excess depress stimulation to lung and heart action, and the first aider should give mouth to mouth resuscitation as a matter of principle if breathing becomes shallow. Closed cardiac massage, a skill requiring specialized training, may become a life-saving skill if the victim's pulse begins to fail.

THE ATTITUDE PROBLEM. The development of an open situation in which one can respect the individual and face his problem head-on requires three basic rules:

1. Do not panic.
2. Treat the student with dignity.
3. Keep communication lines open.

The first rule is a warning against premature judgment and action. When the problem is presented, the coach's preconceived notions or negative attitudes can prevent the encounter from becoming a counseling experience. *Dignity* is the right of all individuals, with or without problems. If the coach truly wants a person to overcome a concern, the concern and the individual must be given legitimacy. As for *communications*, few problems are resolved in one encounter. Often, the real problem will not be shared until after several encounters. Furthermore, just because one problem is solved, or proves to be insolvable, does not mean that the person will be free from subsequent problems. Consequently, the attitude of the coach should always leave a "come back any time" feeling with the student.

However, it is difficult to develop an attitude of acceptance for everything the boy says, and always to consider his opinions and his problems to be important. Curiosity will have to be nurtured so that it asks, "What can I learn from this experience?" By becoming a learner, one comes to appreciate the significance of others'

experiences and the legitimacy of others' interpretations of these experiences.

To illustrate, let's look at a college football coach who, prior to a minor operation was given a "shot." In his words:

> *I'm really quite a private person. I don't project too well outside my own realm of friends, so you might call me somewhat inhibited. But anyway, they gave me the hypo and sure enough, the effects took hold and I started becoming quite uninhibited as they rolled me down the corridor. I had one of these green hats on; I must have looked crazier than the devil. But you know, I waved to the people I could see going by. By the time they got me up into the operating room, I knew it wasn't me there, but it was actually a real nice feeling. The room with those lights up there and everything was great, and I really didn't care what they did to me. The nurse, attaching a big band around my leg close to my private organs, asked me, "Would you mind moving your scrotum over to the left?" And I just looked at her and returned, "Why don't you do it? I think it would be more fun." She looked over at the other nurse, and said, "Dorothy, we got another wise one in here." Well, prior to the surgery I was determined that I would not take any post-operative hypos because I didn't believe in drugs. Yet, I could hardly wait to get that hypo that evening for the pain, even though I wasn't in a great deal of pain. I asked for it, and I went back into that dream world. Now I can see where this thing, this chemical other-world, certainly could become a serious sort of a thing for anyone.*[1]

This same coach had been, in his own words, a hard-nose coach until two years ago. He does not advocate experiencing drugs to become a drug counselor, but one must learn from others why some students do find some pleasure initially in drug use. The ability to apply meaningful discipline requires similar attention to others' perceptions of a problem. To illustrate, this same coach, who used to live completely by the familiar sports management principle, "If an athlete was caught deviating from rules, off the squad he went," continued:

> *I've re-evaluated my thinking. I feel this way about it. A young fellow on our squad, doing a whale of a job, had left the squad having "problems." He had read articles by the former pro football players that football was dehumanizing and athletics were nothing more than the coaches' game and they were tired of this dictatorial attitude taken by the people in charge,*

[1] Personal anecdote related at the Mankato Symposium.

etc. He wasn't asked to leave or anything like that, but he did leave the squad and he got quite involved in the drug scene. This summer I had a long distance phone call from him. He was an excellent football player and there was no question about him helping our football team. I knew the youngster well and I had had many talks with him. And I learned a great deal about drugs from him, by the way. I think once you gain the respect, the doors do open. He wanted to come back. Well, I put it to a squad vote – we have an executive committee of athletes – and they decided he could come back and really help the team. But we had one young fellow on that committee who made quite a point. This young kid says, "Yes, there is no question that he can help the football team; he can help the athletic squad; but I think we can help him more." And as you know, that is the thing that really sticks with me. He was talking about an athlete. To be very honest with you, I knew he could help my football team and I've been in situations like other coaches where things haven't been very nice if we weren't winning. But I do know this: that statement changed my whole outlook towards this drug thing. I feel that we must have the attitude that we – the team – can help them more than they can help us.

The attitude problem can be reduced to one essential principle: *Do not confuse discipline with rejection.* Rules for squads have a reason. Opportunities for sports also have a reason – to many youth, a profound reason. The coach who needs to discipline a rule-breaker can learn to do so while still providing the opportunity for the individual to regain personal dignity and to demonstrate his worthiness for another chance. Perhaps it is the attitude of the coach that determines the purpose of sports in his community. The coach who sees sports as an educational medium will have little difficulty maintaining squad rules for discipline and developing the potential of his individual athletes through the sports experience. However, the coach who sees sports as an avenue for personal glory will evaluate his attitudes accordingly.

THE "PROBLEM" PROBLEM. To fulfill his strategic role as a counselor as well as teacher, the coach must learn to take each youth head-on, with the purpose of sports as his reference point. Each of his athletes is an individual with a basic need to find himself, to learn what he is (and what he is not) so he can make a realistic contract with life. A related basic need is to be "loved" (fully respected as an individual) by at least one person whom he respects.

This aspect of ego development is accomplished by a constant interaction between what the youth feels he is and what he feels his social environment tells him he is.

As all coaches know, many youths have trouble with this interaction. If the coach is helping the boy to find his "right spot," or the right position in a sport, he is helping both the squad and the athlete. This is effective counseling, and some coaches are better at it than others. Also, some coaches are more aware of the alternatives than others.

In striving consciously in this direction, seven steps need to be examined:

1. Interest. An attitude of openness is an ingredient that others can quickly sense. If the athlete anticipates a rigidly negative attitude or expects punishment and nothing else, the coach will not have to worry about problems related to drug counseling; no athlete is going to seek his help. Interest can be cultivated, but it can never be contrived. Until a coach is truly interested in helping individuals, the counseling process cannot begin to function. A coach must try to look at a problem head-on and to understand that people with problems are to be respected. A professional attitude has to permit an individual with a problem to feel that he can maintain (or regain) respect from his peers *and* the coach.

2. Observation. A coach who takes an interest in individuals will come to observe subtle changes that may reflect progress or regression. Because the coach sees youth in maximal effort situations regularly, his observational powers are strategic in stemming a budding problem. Other professionals simply do not have this unique opportunity. The best early diagnostic sign of a drug problem is not dilated pupils or needlemarks on the arm, but is a change in lifestyle, or personality. These changes may not be caused by drugs, but they do warrant immediate attention by a trusted professional.

3. Encounter. Whether by opportunity or by obligation, encounters between athlete and coach take place. The "rapport" we read of in books as being vital to such encounters is not one in which the student and counselor become friends; it simply is a state of mutual respect. This distinction assists the coach who, like any other professional, asks the question, "If the student does not agree with my values, how can I befriend him?" A coach can respect any athlete as an individual with a right to be himself, to make mistakes, and to demonstrate that he can learn from mistakes.

4. Empathy. Too often, coaches cannot conceive of themselves as counselors because of their impatience with the client-centered philosophy of counseling. If they cannot sympathize with the athlete and his problem, how can they respect him and counsel him honestly and effectively? The answer is *empathy.*

Empathy is not sympathy. In fact, sympathy is dangerous; it is a feeling that *influences* attitudes or behavior. (It is not necessarily a feeling *for* the person.) A coach who falls into the trap of being sympathetic is no longer a professional person. Empathy, on the other hand, is one's ability to step into another's shoes, to see "reality" through his eyes, and then to *get back into one's own shoes before acting.* This permits a disciplinary action, if for the boy's own good, but without rejection. A person who is never called to task for repeated infractions is done no service; similarly, a person who responds to stress in an undesirable manner may respond to appropriate discipline or probation if the source of the behavior is mutually understood.

The encounter consequently must be accompanied with an empathic attitude if a reasonable course of counseling action is to progress.

5. Understanding. A coach who, through empathy, comes to understand the problem can come to understand approaches to the problem as well. An understanding is in essence a contract between athlete and coach as to what is to happen. A contract is a type of mutually accepted agreement of, "I'll do this for you and you'll do this for me." For example, when a boy becomes a candidate for a squad, he contracts with the coach to abide by the rules, the code of conduct to complete the season regardless of wins and losses, etc.

If, through a counseling encounter, a contract can be agreed upon as a course of action to get at a problem, it will help bind the good faith of the athlete with the good faith of the coach. The contract may be short-term so that readily attainable goals can give immediate satisfaction and still permit new and progressive contracts to be formulated. However, the key ingredient to a contract is arriving at a mutual understanding as to the length and terms of the contract period. By considering this a mutual understanding, *both* parties are obliged to keep the faith.

6. Resources. The nature of the contract is influenced heavily by the resources of the community. If the coach is lucky, there is a drug crisis intervention center in the town that can take inquiries and emergencies 24 hours a day. If not, the coach is on his own and must

acquire knowledge from a variety of professional individuals and people of the street who share his concern about helping youth survive adolescence.

It must be remembered that some drug problems are not chemical problems. The drug scene contributes to premarital pregnancies, venereal disease, infectious hepatitis, vocational lethargy, personality deterioration, social alienation, etc., all of which can be helped by respective professional services. The coach who is not aware of the available resources will have difficulty fulfilling his part of the contract.

7. *Advice.* The end result of a counseling experience is the advice given. The advice may be to see someone, or to do something, or to consider something. But if the encounter has reached this stage, the advice given is not as important as the manner in which it is given. Advice stemming from these seven steps is given in good faith and not from Mount Olympus. That someone cares is often enough to permit the athlete to locate the factual information he needs.

Since the evaluation of counseling advice is always done with hindsight, and since the need of the individual is more in terms of respect than information, a counselor need not allow fear of giving poor advice to hinder his willingness to become a counselor. New contracts can be written if the previous ones emerged from mutual good faith.

An example of "advice" *not* given in good faith is the tacit approval of a destructive action. The coach who turns his back on an athlete's drug use is saying, "Go ahead and take it; just don't let me know about it." This type of advice will ruin sports—the proper role of sports—faster than any other action a coach can take. When a coach defaults, he loses the respect of his athletes, he breaks his contract with both his athletes and his school, and he gives nourishment to the detractors of sport.

Synopsis

The purpose of this publication is not to tell the coach what to do, but to provide him with a perspective for sharing in what must be done. It's time that coaches take the offensive in drug education. There are more "teachable moments" in a sports experience than in most other activities affecting young people. The coach is the teacher, leader, and counselor who accompanies these experiences. To default in these goals is to prostitute sport. In this regard, the following checklist items should be of help.

1. Do I utilize sports as an educational experience?
2. Do I keep in mind the basic concept of doping to simplify for myself and for my athletes the appropriate role of drugs in sports?
3. Do I utilize the concept that examining the purpose of drug taking is far more central to counseling-teaching than the effect of drug taking?
4. Do I utilize discipline instead of rejection in handling a drug-related problem?
5. Do I utilize empathy in my encounters?
6. Do I respect the significance of the "Problem"-Problem?

"It would be far more effective and on target if the energies of coaches and others in sports were focused on the protection of, *instead of* from, *the athlete who faces defensible as well as indefensible uses of drugs."*

If these items can be answered in the affirmative, a coach can act in good faith. Consider the athlete who resigns from the squad because, in his words, he finds a social benefit from smoking marijuana. First of all, the coach would find pride in that (1) the athlete respects him enough to tell him the truth; and (2) the athlete respects a contract enough to resign instead of merely to drop out. By examining with the ex-athlete his purpose in using marijuana, (i.e. to communicate better), the coach neither panics nor moralizes (for the athlete obviously "does not have a problem"); but he does help the ex-athlete crystallize his own stated reason for the action. The lines of communication remain open to periodic discussion of the effects of the drug compared to the purpose (i.e., the coach can ask, "Do you now communicate better when not on the influence of marijuana?") and to make it as easy as possible for the boy to ask for help if he comes to find he *has* a problem.

As for abuses to doping, the hue and the cry has been for protection *from* the athlete who dabbles in drugs. There is no question that a black market availability of "doping" drugs exists – and a market does not exist where there are no consumers. As long as the athlete feels that his opponent has an advantage by taking a drug, he is tempted to dabble as well.

However, it has yet to be proved that drug users have an edge on nonusers. A sports drug no more reliably enhances performance beyond one's normal capabilities than a street drug resolves personal problems. It would be far more effective and on target if the energies of coaches and others in sports were focused on the protection *of*, instead of *from*, the athlete who faces defensible as well as indefensible uses of drugs. This would include what has not been discussed in this publication – the harm to person and community from the use of street drugs called alcohol and tobacco. The facts on the harm done by these drugs is as convincing as for other street drugs, for those who want to read them.

Appendix

Structure for a Symposium on "Drugs and the Coach"

First day – THE PROBLEM

1:00 p.m.	Welcome
1:05 p.m.	Opening Remarks – National official, Athlete M.D., Athletic Trainer Coach
1:30 p.m.	A Perspective for Coaches Concerning Drug Use and Abuse
2:00 p.m.	Sports Drugs: Classification
2:30 p.m.	Coffee and Coke
2:45 p.m.	Anabolic Steriods and Athletes
3:10 p.m.	Amphetamines and Athletes
3:35 p.m.	Drug Controls in Athletics
4:15 p.m.	Audience Participation – Moderator and Panel
5:15 p.m.	Dinner Break Share concerns with fellow registrants
6:30 p.m.	Street Drugs: Classification
7:00 p.m.	Legal Aspects of Drug Use
7:30 p.m.	Street Drugs and the Athlete
8:00 p.m.	Audience Participation – Moderator and Panel
9:00 p.m.	Cracker-Barrel Session Meet faculty and fellow registrants informally. Refreshments provided.

Second day – THE POTENTIAL

8:30 a.m.	Coffee and Rolls
9:00 a.m.	Overview of Drug Counseling
9:15 a.m.	The Encounter with the User
9:45 a.m.	Talking to the Young Athlete
10:15 a.m.	Audience Participation – Moderator and Panel
11:00 a.m.	Perspective: Implications for the Administrator Audience Participation – Moderator and Panel
11:45 a.m.	Adjourn
1:30 p.m.	Football Game (registrants are guests)

Sources of Drug Abuse Information

AMA Committee on Medical Aspects of Sports
American Medical Association
535 South Dearborn Street
Chicago, Illinois 60610

National Clearinghouse for Drug Abuse Information
Educational Services
Parklawn Building
Room 8C-09
5600 Fischers Lane
Rockville, Maryland 20852

National Coordinating Council on Drug Education
1211 Connecticut Avenue, N.W.
Suite 212
Washington, D. C. 20036

Special Action Office for Drug Abuse Prevention
New Executive Office Building
726 Jackson Place, N.W.
Washington, D. C. 20506

United States Office of Education Drug Education Program
Reporters Building
7th & D Streets, S.W.
Washington, D. C. 20202
Attention: Dr. Helen Nowlis, Room 414

OTHER SOURCES:
State Department of Education of the respective states.